

# ASSESSING THE NEED TO ENACT MEDICAL LIABILITY REFORM

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## HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED EIGHTH CONGRESS FIRST SESSION

FEBRUARY 27, 2003

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## **ASSESSING THE NEED TO ENACT MEDICAL LIABILITY REFORM**

**THURSDAY, FEBRUARY 27, 2003**

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON ENERGY AND COMMERCE,  
SUBCOMMITTEE ON HEALTH,  
*Washington, DC.*

The subcommittee met, pursuant to notice, at 10:08 a.m., in room 2123, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Barton, Upton, Greenwood, Deal, Burr, Norwood, Shadegg, Pickering, Buyer, Pitts, Ferguson, Tauzin (ex officio), Brown, Waxman, Pallone, Eshoo, Stupak, Green, Strickland, Capps, DeGette, and Dingell (ex officio).

Staff present: Cheryl Jaeger, majority professional staff member; Nandan Kenkeremath, majority counsel; Patrick Morrissey, deputy staff director; Eugenia Edwards, legislative clerk; Steve Tilton, health policy coordinator; David Nelson, minority economist; Jonathan Cordone, minority counsel; Nicole Kenner, minority staff member; and Jeff Donofrio, minority staff intern.

Mr. BILIRAKIS. The subcommittee will come to order.

Without objection, the subcommittee will proceed pursuant to committee rule 4(e). No objection having been heard, so ordered.

The Chair recognizes himself for an opening statement.

First, I would like to thank our witnesses for appearing before this subcommittee today. Our committee certainly values your expertise, and we are grateful for your cooperation and attendance.

The Health Subcommittee held a hearing last year,

hearings over a period of time have been held on this subject, to learn more about a major crisis in our health care system, namely how spiralling professional liability insurance premiums are adversely affecting patient access to care.

I know that during our hearing, the last hearing, there were diverging views about what was causing this spike in insurance premiums and what potential solutions might look like. However, there was no debate about the fact this crisis is beginning to have a devastating effect on patient access to health care; and I know that my constituents—and I would like to think all of our constituents—are demanding that Congress act in some way to control these run-away insurance premiums.

Fortunately, Congress does have a model to draw on. California's Medical Injury Compensation Reform Act, or MICRA, has helped shield our Nation's largest and most diverse State from the huge increases in insurance premiums that so many other States like

Florida are struggling with. In fact, according to data compiled by the National Association of Insurance Commissioners, California's medical malpractice insurance premiums have increased 167 percent from 1976 to 2000, while the rest of the country has experienced increases of 505 percent. California's experience suggests to me that meaningful tort reforms can have a very positive effect in terms of controlling increases in professional liability insurance premiums.

MICRA was the foundation of H.R. 4600, the Health Care Act which the House of Representatives passed during the last Congress. While I was disappointed in our inability to send a bill to the President for his signature, I am looking forward to the opportunity that we have before us during this Congress. The crisis has certainly not gone away and nor has our need to act.

While I believe that last year's Health Subcommittee hearing provided members—and we had much debate during our markup—with an excellent opportunity to learn more about this issue, I think we can all benefit from further discussion. I remain especially interested in learning more about how insurance premiums are determined. I know we have heard from many people on the other side and from witnesses that much of the problem has to do with the insurance industry and whatnot. Well, we need to know that. We need to learn more about it. So we also need to know about how meaningful tort reform is going to control increases and professional liability and insurance premiums.

Again, I would like to extend a warm welcome to all of our witnesses. I would like to take a minute to welcome back Mr. Hurley, Jim Hurley, Chairperson of the American Academy of Actuaries, Medical Malpractice Subcommittee. I thought your testimony, Mr. Hurley, at last year's hearing was invaluable; and I know that we all appreciate the independent, objective perspective your organization provides on how actuarial standards relate to how insurance companies develop premium levels.

While I am well aware of the range of opinions regarding this issue in the Health Subcommittee, I sincerely hope that members take advantage of the expertise. Frankly, I would love it if we could all focus on the one area that we keep hearing about and that is the effect that the insurance companies have on this particular problem. But I can't really shut off what one might choose to do with our time. But I do hope we will take advantage of the expertise we have before us to learn about the causes of this crisis and potential solutions.

I now yield to the ranking member, my friend from Ohio, for an opening statement.

Mr. BROWN. Thank you, Mr. Chairman; and thank you for your cooperation in this issue and your willingness to work with both sides and come up with a real solution to medical malpractice.

I ask unanimous consent to enter into the record member statements, including Mr. Dingell's here if I could.

[The prepared statement of Hon. John D. Dingell follows:]

PREPARED STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS  
FROM THE STATE OF MICHIGAN

Mr. Chairman, thank you for holding this hearing to assess the issue of medical liability. Although this hearing has been broadly cast to cover a wide range of inter-

ests that extend beyond doctors and patients, it is an appropriate opportunity to address the rising cost of malpractice insurance, which is a very real problem for doctors and patients alike.

These high insurance rates are leaving doctors with few options. Those who can afford to pay the increased cost of providing medical services, will. Those who cannot afford the increase are forced to assume significant personal liability, leave high-risk specialties, or leave the profession altogether. At best, health care will become more expensive for patients. At worst, in addition to higher prices, patients will be denied access to care, and lifesaving treatments will not be provided.

This is a serious problem that deserves deliberate consideration. Unfortunately, legislation pending before this committee, H.R. 5, focuses on drastic reforms of the judicial system that extend well beyond the issue of medical malpractice. While inefficiencies in our courts may be a contributing factor to this crisis, it is by no means the only cause—or even the single largest cause—of the current crisis.

As the subject of this hearing appropriately indicates, the protections of H.R. 5 extend well beyond the doctor-patient relationship. The provisions contained in this bill will shield HMOs, insurance companies, and drug and device manufacturers from liability. No evidence has been presented to the Committee demonstrating that these privileged industries need additional protections, yet H.R. 5 grants them a special status under the law that is unprecedented.

Moreover, these dramatic protections hurt the rights of injured patients in an equally unprecedented manner. There is a human cost to this legislation that we must not forget. We will hear from a courageous and impressive young woman today, Heather Lewinsky. She will explain how her life has been affected by the malpractice of a plastic surgeon. The pain, suffering, fear, and trauma that Heather has courageously confronted are real, and she should be compensated. And the loss of seventeen year old Jessica Santillan must be devastating to her family. If malpractice is to blame for young Jessica's passing, as it certainly appears, her family should be compensated for their loss. Neither Heather nor the Santillan family would qualify for significant economic damages. The harm caused to both is almost exclusively non-economic in nature, but it unquestionably is still great harm.

While claiming to provide unlimited economic damages, H.R. 5 would disproportionately hurt women, seniors, and low-income families by limiting non-economic damages to \$250,000. Because a significant component of economic damages is an individual's income, such a system would disproportionately value the lives of those with high incomes over low-wage earners, stay-at-home moms, and senior citizens. For example, if the CEO's of the very drug companies and HMO's that this bill protects were injured, their economic damages would be worth millions upon millions of dollars. By comparison, if a stay-at-home mom were injured in an identical manner, she would have very limited economic damages awarded to her.

H.R. 5 also limits the amount of time in which an injured patient can seek just compensation to three years from the date an injury manifests itself. The concept of manifestation is not established in law nor is it clearly defined in the legislation. There are certainly circumstances when an injury could manifest itself without a patient knowing of its existence for three or more years. An illness such as HIV could manifest itself and not be discovered—nor expected to be discovered—by a patient for many years. This legislation would prevent that patient, and many others, from being compensated at all.

Unfortunately, my Majority colleagues are quite determined to move quickly and harshly. Their legislation reaches well beyond malpractice and offers no guarantees of assistance to providers and communities. Physicians and patients are asked to cross their fingers and hope that some of the benefits given to insurance companies and large corporations will trickle down to them. And women, seniors, and low-income families are left to pay the very real price of these benefits. It is wrong.

But the rising cost of malpractice insurance is a real problem—requiring careful, balanced, and targeted legislation. I am in the process of finalizing legislation that will provide direct, targeted assistance to physicians and communities to assist with the current crisis. It will also institute limited, common sense tort reforms to weed out frivolous lawsuits and provide stability in our courts while protecting the fundamental rights of patients. Lastly, the legislation I will propose would create an independent commission to examine every aspect of the current insurance crisis, propose additional solutions to address the current crisis, and make recommendations to avoid any future malpractice insurance crisis. I hope that at some point in the process a balanced approach such as this will prevail, but I'm not holding my breath.

Mr. BILIRAKIS. Without objection, the opening statements of all members will be made a part of the record.

Mr. BROWN. First of all, thank you to all the witnesses; special thanks to Heather Lewinski for her courage and for joining us. Thank you, Heather, and thank you all of you.

I would suggest that our efforts in this legislative process be guided by the following principle: A good medical malpractice reform bill should prevent outrageous increases in medical malpractice premiums and improve access to quality medical care.

This principle embodies two concepts: We should ensure that the bill will—not may but will—address premium spikes and improve access to care, and we should ensure that the bill does not reform away the medical malpractice liability system’s role in promoting responsible quality medical care.

Let me briefly explore each of these ideas, Mr. Chairman.

The professed goal of medical malpractice caps is to introduce more predictability into the system. Uncertainty, our friends in the insurance industry say, is what really endangers patient’s access to health care. This is an important point. Insurers make an actuarial calculation of the additional premiums needed to counter uncertain jury awards. They literally put a number on it. It follows, insurers tell us, that we can easily stem the medical malpractice premium crisis by capping jury awards. No more uncertainty means no more premium spikes.

The industry doesn’t explain, though, how uncertainty, which has been a part of the system for years, can possibly explain the recent spike in premiums, but it would be a shame to let a silly little thing like logic ruin a good story.

The industry balks when anyone dares suggest that insurers demonstrate that they are, in fact, reducing premiums in response to the caps. The insurance industry and my friend Mr. Greenwood, who helped kill an amendment to last year’s bill that would establish this requirement, claimed that it can’t be done. Apparently, insurers can make an actuarial calculation and increase premiums to compensate for uncertainty, but they cannot make an actuarial calculation and decrease premiums, decrease premiums when that uncertainty is diminished.

I understand why insurers and the bill’s sponsor would fend off attempts to require proof that this bill accomplishes its ostensible goal. After all, liability caps are reversible. But because liability caps raise serious equity issues, serious ethical issues, I would suggest that any measure that fails to ensure that insurance company savings from damage caps are passed on to doctors, that savings from caps are passed on to doctors in reduced premiums, they simply can’t meet the first part of our test for malpractice legislation. It cannot ensure that our actions will improve access to care.

Let me suggest a way to reduce doctor premiums and increase access to quality medical care. It is pretty straightforward. All we need to do find out what the problem is and fix it.

Insurance companies won’t provide the information we need to understand recent premium increases. They won’t demonstrate how their bottom line has actually been affected by jury awards, by investment income or the lack thereof, by past rate-setting decisions and the like. When asked to provide this information, the industry says that is proprietary information. We can’t give that to you.



So Congress—get this. Congress is expected to pass legislation that caps compensation to patients whose lives have been irreparably harmed by medical malpractice without any concrete evidence that the cause of the crisis stems from higher unpredictable jury awards because the insurance industry won't tell us. It is more important to protect proprietary accounting information for that industry than it is to protect patients who have been injured. Have our values drifted that far off course?

Mr. Chairman, this subcommittee doesn't have to legislate in the dark. We have the power to subpoena, to subpoena insurance company records and discover for ourselves what is actually going on here. I have offered this suggestion to the majority before but to no avail. It is not too late. We can dispense with the glossy arguments and competing statistics. We can get to the bottom of this problem. We can pass a bill that addresses it. But to do that we need to subpoena the records of medical malpractice insurers. It is irresponsible to move forward without doing that.

The second element of our guiding principle is equally straightforward. Our actions must not compromise the effectiveness of America's medical malpractice liability system. Doctors are as close to miracle workers as we have in our society, but, like the rest of us, they are not perfect and in a few cases there are a few bad guys. When doctors don't do their jobs, patients suffer. As Heather Lewinski's testimony today amply demonstrates, that suffering is personal, and it is lifelong.

Proponents of Mr. Greenwood's health bill say the bill is actually patient friendly. After all, it doesn't cap economic damages. But Heather was 8 years old when a doctor's negligence changed her life forever. She obviously had no job, she had no prospects for employment when she was 8 in the foreseeable future, and she was awarded as a result no economic damages.

Under the health bill, Mr. Greenwood's bill, the punitive cap is kept at the lower of \$250,000 or double the economic damages.

One more moment, Mr. Chairman.

Mr. Chairman, two times zero is still zero. This bill would literally tell children like Heather that the value of punishing people who harm them is, in fact, zero.

The issue of medical malpractice is an important one, deserving a serious sincere effort by this committee. We can still develop legislation that improves both access to and quality of care. I hope that this subcommittee will do that.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Greenwood, for 3 minutes or would you defer?

Mr. GREENWOOD. I think I will take my 3 minutes, Mr. Chairman.

Mr. BILIRAKIS. I am not surprised.

Mr. GREENWOOD. It is my bill, after all.

What can we agree on? I don't think it is difficult for us to agree that we have a crisis with regard to the availability and the cost of medical liability insurance. I don't know anyone who disagrees with that.

In my State of Pennsylvania, the crisis is particularly acute. We have lost 900 doctors. The trauma center that would serve my family and the families of most of the people that I represent closed

its doors in December because it could—because of its incredibly exorbitant increase. I think the insurance rates went from \$7 million a year to \$21 million a year. They are only open now on the promise from Governor Rendell that he will do something before this, and I remain very skeptical that that will happen. So there is a crisis.

The question, of course, is how do we fix the crisis? Mr. Brown has agreed we ought to fix the crisis. Mr. Brown assigns blame to the insurance companies. I can assure you that if I thought that there was a fix there I would fix it. I have no particular reason, I don't know of anybody who has a particular reason to not go after the insurance companies if that is where the problem is.

But here is the problem with that argument: 60 percent of the doctors in this country get their medical liability insurance from physician-owned companies. Physician-owned companies have as their purpose trying to provide physicians with the lowest available priced policies.

Now, if these physician-owned companies are not able to underbid the private insurance companies that some are claiming are price gouging, then where is the logic? Where is the logic that says that the price spikes are caused not by the environment of the courtroom and the excessive noneconomic damages that are paid but somehow lies in the management practices of the insurance companies when, again, 60 percent of the doctors in this country get their malpractice, if they can, from physician-owned companies, and 30 percent in my State of Pennsylvania get their medical liability insurance from physician-owned companies?

The gentleman from Ohio suggested that, gee, all we need to do is get the insurers in here to open their books and get the information. My understanding is that the Democrats did not invite any insurance companies to come in and be questioned at this hearing. We have had actuaries testify at hearing after hearing as to the causes of the price spikes. I think their testimony has been very direct and supports the logic of the bill.

The bottom line is we need to get this crisis resolved. We need to find a bipartisan way to do it. We need to do it in the House and the Senate. I personally am open to whatever works, but it will be a failure of the Congress and a waste of our time if we pass legislation that becomes so watered down that we get 218 votes in the House and 51 votes in the Senate and 60 votes to break a filibuster and sign it into law and it doesn't solve the crisis. I think we ought to be focused on solving the crisis, solving it rationally and not being partisan about it.

Thank you, Mr. Chairman.

[The prepared statement of Hon. James C. Greenwood follows:]

PREPARED STATEMENT OF HO. JAMES C. GREENWOOD, A REPRESENTATIVE IN  
CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. Chairman, I thank you for holding this hearing. Today, I look forward to hearing from our witnesses as we explore, examine and confront the medical liability insurance crisis.

The word "crisis" is often thrown around in Washington DC but let me tell you something that fits this term, under any definition: From December 21 until January 3 of this year, for thirteen days, the trauma center of Abington Hospital, in Abington, PA closed its doors because the doctors staffing this critical facility could not obtain the affordable medical liability insurance they needed to practice. For those

thirteen days, fundamental protections to the health and the lives of the families in this area ceased to exist. How have we come to this?

The purpose of this hearing is to help this committee—and the public—learn and understand the events and forces contributing to the growing inability of people across the country to find a doctor. What is more, we need to understand why Americans in many states can no longer go about their daily lives knowing that if the worst happens—the doctor is in place and on call.

In the Philadelphia region we have a special obligation and a proud legacy to protect. Since 1751, when the founders of Pennsylvania Hospital, Benjamin Franklin and Dr. Thomas Bond, opened the doors to the nation's first hospital, we have been a leader in health care. Even today, almost one in seven doctors in the United States did some part of their medical training in Philadelphia, which is home to a host of excellent medical schools and institutions.

But the signs appear ominous and this legacy is threatened. Recently, Methodist Hospital in south Philadelphia, which has served that community for more than 100 years was forced to close its obstetrics practice. Why? And what hardships have been visited upon the expectant mothers who counted on those services?

This crisis affects more than just patients and doctors. In an Energy and Commerce Oversight and Investigation Subcommittee hearing I chaired on this crisis in my home district on February 10, 2003 we heard from two hospitals and trauma centers operating in southeastern Pennsylvania, St. Mary Medical Center and Abington Hospital about the problems growing day-by-day to find and retain the physicians needed by these facilities to keep open their doors.

I am deeply saddened and angered that this crisis is having permanent and long-term effects: Weakening hospitals, debilitating medical schools, reducing the number of doctors who practice, and destabilizing health care institutions—all to the detriment of the people desperately in need of skilled medical treatment.

Again I ask: Why? that is the question we seek to answer here today.

Let me tell you what I know so far. The access to health care has been restricted because the individuals and institutions delivering that care cannot find the affordable insurance required to practice medicine. Insurance companies are raising their rates across the state and turning down doctors looking to find new policies.

What is happening to insurers? Insurance companies set their premiums based on their risk—the amount they estimate they will have to pay. You would naturally expect to pay more to insure a \$50,000 home than a \$500,000 home. What do you think an insurance company would say to someone who wanted to insure a house, but could not tell the value except that it could be worth either \$10,000 or millions? Pennsylvania medical liability insurers face a similar quandary. They simply cannot make reasonable business decisions of their risk when they don't know with each passing year what juries will award.

In the past 3 years, according to a recent Wall Street Journal editorial, juries in Philadelphia have awarded more in medical damages than the entire State of California. In 2000, Pennsylvania had 19 awards individually exceeding \$5 million.

In light of this, can we begin to understand why Pennsylvania insurers, facing the unpredictability of Pennsylvania court verdicts, continue to increase their rates? Can we then see why Pennsylvania's largest physician insurer this year raised its premiums an average of 54%? Does this help us start to recognize why 72% of Pennsylvania doctors, according to a 2001 survey, deferred the purchase of new equipment or the hiring of new staff because of malpractice costs? And now can we see why, since January 2001, more than 900 Pennsylvania physicians have closed their practice, moved out of state or refused to do high-risk procedures?

I asked "why" earlier. Let's trace the problem back to this fact: Insurers cannot properly, reasonably and competitively offer insurance to medical providers because of an unpredictable tort system prone to "jackpot" awards.

No one will argue that patients injured by the negligence of a medical provider do not deserve compensation—but we have lost all sense of proportion in the area of non-economic, intangible damages. How do we put a price tag on suffering, loss of enjoyment of life, or embarrassment? A jury of peers is the best and fairest system of justice we have. They make decisions of profound importance every day across the country based first on the rule of law but second on their sense of justice.

But we must ask: What informs, what creates this sense of justice and gives it proportion? How have we set benchmarks for putting a dollar value on another person's pain or embarrassment? Are we guided by the amounts we see in sensational headlines or advertisements of lawyers trumpeting huge recoveries? Are we guided by the woman who won millions for spilled McDonald's coffee? Where ever we found that price tag we hang on another's suffering—it is clear that all sense of proportion seems to have been lost.

Reasonable caps on such subjective damages, in my estimation, when teamed with a specific package of other reforms, will bring juries, verdicts and insurance rates back to earth.

I have recently introduced legislation in the House designed to address this root problem. However, I am ready to work with members on both sides of the aisle, in both chambers to achieve a solution that will be signed into law by the President.

Again, thank you to the two committees for holding this joint hearing.

Mr. BILIRAKIS. I thank the gentleman.

Ms. Eshoo for 3 minutes, unless she would prefer to defer.

Ms. ESHOO. Good morning, Mr. Chairman. Thank you for having this hearing.

For 2 years now we have been discussing and debating what to do with medical malpractice premiums. Clearly, there is a problem. What is not so clear is what our solution should be.

I am a Californian, and in my State we have a law that we have heard mentioned many, many times, MICRA. The bill was passed by a Democratic legislature, and it was signed by a Democratic Governor in 1975. It has been on the books ever since without a single change. While it may not be the sole reason why premiums in California have stayed reasonable and stable, I think that it has contributed.

Representative Greenwood has introduced a bill that he has described as a Federal version of MICRA. What I want to use my time for respectfully is to dispute that assertion. Because it is not the same. The bill places a \$250,000 cap on noneconomic damages for suits against physicians, insurers, HMOs, nursing homes and drug and medical device manufacturers. MICRA limits that cap solely to physicians. H.R. 5 also places a cap on punitive damages. MICRA does not.

One of the reasons MICRA has worked is because it is proscribed in its scope. If we want to get to the heart of this problem, we should focus our efforts on those who really need the help. I am very concerned that extending these provisions to those outside of the physician community will have a deleterious effect on patient care and on our legal system. We can do tort reform and weed out frivolous lawsuits. We have done it before. I was a part of that.

Additionally, H.R. 5 doesn't set up any mechanism to review the insurance industry. They are clearly a part of this. It is not about assigning blame. You have to look at all the stakeholders. California's MICRA has never been updated for inflation since it became law.

I think there is a downside of it I think that is worth mentioning. \$250,000 from 1975 is worth approximately \$68,000 today. We should think about indexing for inflation if we are to do anything at the Federal level. Patients should be fairly compensated for any wrongs that are visited upon them because every life has worth, regardless of whether they have an income or not.

So I look forward to hearing our witnesses giving their testimony today on these issues and others, and I thank the chairman for holding this hearing.

Mr. BILIRAKIS. I thank the gentlelady.

The chairman of the full committee, Mr. Tauzin.

Chairman TAUZIN. Thank you, Mr. Chairman. Thanks for holding this hearing as we try to, as the gentlelady from California indicated, use the experience of States like California and my own in

Louisiana to try to help with the problem that has now become a huge national crisis.

I don't have to dwell on the problem. I think we all understand it. When trauma units close down and obstetric services are denied people and pregnant women can't find a doctor to help them deliver a child because the doctors have gone out of business in their community. The system is creating health care victims that have nothing to do with lawsuits and medical errors. It just has to do with people that can't get health care.

In Louisiana, we are seeing an extraordinary occurrence. Let me be honest with you. We in Louisiana passed medical liability reform. I voted against it when I was in the legislature. I am a convert to the principle. I watched it work. I watched it have the good effects in Louisiana that we saw in California. I watched in Louisiana incredibly as more and more physicians from the neighboring State of Mississippi are moving into our State because they can't anymore stand the pressure of lawsuits and insurance costs in the State of Mississippi.

I talked to Mr. Pickering about that. I go hunting in Mississippi a lot. I wouldn't ask everybody from Mississippi to move from Louisiana. Doctors, okay, but that is not a good way for them to make a choice. The fact of the matter is that when people who have dedicated their lives to serving the health care needs of their neighbors find they have to leave their home State, go live in another State because the liability system is driving them to a point where they no longer look at patients as people who need care but they look at them as potential plaintiffs—

I have a young member of the family who is a physician. He is a urologist in Thibodaux. He is my younger sister's husband. I watched him go to medical school, brilliant young man. I watched him go through his medical training. I watched him come back home to Thibodaux. He performed amazing surgery on my father. It made such a difference in his health. And I watched him perform those medical miracles on friends of mine throughout my community. He got roped into one of these suits not too long ago, and he defended it successfully. He was roped into a suit brought against the hospital he works in. It has changed him. I have seen what was such an incredible feeling he had about his work and his life and what he was doing to help people become a much more cautious and cynical sort of approach. He still loves his work and does great work, but he is a changed man, having gone through that experience.

I know that doctors who might help one another avoid medical error don't share information today because of fear of lawsuits. I know doctors prescribe a lot more medical tests and drugs and all sorts of things to people in my home community, even with our medical reform, because they are afraid if they don't do these things, even though they don't think they are necessary, somebody is going to call that malpractice and drag them through the courts.

Now, I am a lawyer. I am a recovering lawyer I keep telling people. I used to handle plaintiff cases when I was in practice, and I value a legal system that gives people a right of redress when they have been harmed. But the legal system needs always to be bal-

anced and sometimes rebalanced to make sure it doesn't do more harm than good.

While we need to preserve the right of people to recover when somebody wrongfully kills their child because of malpractice or wrongfully hurts someone's mouth because of bad dentistry, whatever, it may be we need to preserve those rights and make sure there is adequate and fair recovery. We also need to be concerned about the young men and women who dedicate their lives to taking care of parents and neighbors and their friends and who suddenly today look upon their patients with fear instead of the kind of loving attention that they came out of medical school determined to show whenever they entered a hospital or surgery room to do a medical procedure. I think it is time for us to balance this out on the Nation.

This medical liability reform bill patterned after what was done in California, my home State of Louisiana is I think the kind of medicine we need to make sure we aren't creating more victims unnecessarily in this system, to make sure that, in fact, people get rewarded properly when there has been an injury but we don't encourage lawsuits where 60 percent of them today are either dismissed or withdrawn and where 58 percent of the recovery goes to somebody other than the victim, the patient.

We need some work here. We need to balance this out a little better. We need to give the doctors and nurses and health care personnel in our country a little bit of credit. We need to understand they didn't dedicate their lives to service just to be in a lawsuit every other day.

I thank you, Mr. Chairman.

[The prepared statement of Hon. W.J. "Billy" Tauzin follows:]

PREPARED STATEMENT OF HON. W.J. "BILLY" TAUZIN, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Thank you, Mr. Bilirakis for holding this timely hearing.

Mr. Chairman, our legal justice system is out of balance. Excessive litigation is driving up health care costs, forcing doctors to leave their practices, causing hospitals to shut down and leaving America's patients in a state of "code red."

We have seen this issue all over the news in recent years. Last year, we heard about a Level 1 trauma center in Las Vegas closing, forcing severely injured patients to travel an additional 500 miles for equivalent care. In Mississippi, one-third of the neurosurgeons have left the state—an incredible number especially when you consider the substantial toll stroke has on the state. In West Virginia and Pennsylvania, obstetrics units have closed, leaving some pregnant women without direct access to a qualified physician to deliver their baby. The stories go on and on. Patients are being victimized by a lack of access to certain health care services across our country, partially because of a runaway tort system.

For those of us who have served in our state legislatures, this issue is not new. Louisiana once faced a similar patient access to care crisis. My state responded by enacting medical liability reform that has withstood constitutional challenges as well as attempts to dilute its effectiveness. Their guidelines for health care lawsuits ensure that injured patients receive greater compensation while at the same time deter frivolous lawsuits that extort health care professionals and drive doctors from the practice of medicine. While medical liability insurance rates have skyrocketed across the country, doctors are not leaving their practices in the state of Louisiana. In fact, over the past year, doctors in neighboring states have sought refuge in Louisiana. Of course, we love having more people come to our state, but I don't think this is the way we want to accomplish it.

I know those advocating for federal legislation modeled after California's Medical Injury Compensation Act feel quite the same way as the doctors in Louisiana do: medical liability reforms work and they really do have an impact on patient care. Without medical liability reform, fear of lawsuits deters doctors from sharing infor-

mation that is critical to learning how to prevent systematic mistakes, stymieing efforts to reduce medical errors and improve patient safety. Without medical liability reform, doctors will continue to engage in defensive medicine, performing tests and prescribing medicines that are not necessary to better the health of the patient, driving up health care costs for all Americans.

And the costs to the system are not insignificant. Some analysts estimate tort reforms could lead to reductions of well over \$50 billion per year in health care expenditures, without serious adverse consequences for patients. Without medical liability reform, insurance rates will continue to force doctors out of practice, leaving some patients without access to health care. Because when doctors spend less time thinking of a patient as a "potential lawsuit" and more time treating the patient, the patient receives better care.

I have said it before, and I will say it again. When injured patients have to wait, on average, 5 years before a medical injury case is complete, our judicial system has failed. When injured patients lose 58 percent of their compensation to attorneys and the courts, our judicial system has failed. When 60 percent of malpractice claims against doctors are dropped or dismissed, but the fear of litigation still forces doctors with twenty-five years of experience to retire early, our judicial system has failed.

Members of this Committee have taken the lead in drafting legislation to help restore some degree of common sense to our tort system. We realize that our current system is too slow, too expensive, too inefficient and most importantly, fails to improve the health of our country. I applaud the Members of this Committee for the leadership and thoughtfulness they have shown in advancing legislation to address this critical issue.

Today, I look forward to the witness testimony. And I encourage all of my colleagues, on both sides of the aisle, to listen carefully to the information presented by the witnesses today. It will, no doubt, prove useful as we move forward H.R. 5, the HEALTH Act, through subcommittee and full committee mark-ups next week.

Mr. BILIRAKIS. Mr. Stupak.

Mr. STUPAK. I will waive, Mr. Chairman.

Mr. BILIRAKIS. All right. Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman.

The highest maxim of the medical profession is "first do no harm." in other words, unless a patient will benefit from amputation, the doctor should not cutoff their leg. As legislators, I think we should also be served by following the same maxim. Unless the people will benefit from a reduction in their rights, we should not reduce their rights.

Now, we all know that doctors, particularly doctors in some practice groups and subspecialties, are suffering from high insurance rates. But what we have learned from hearings both last year and last month is that there are serious reasons to question claims that capping damages in medical malpractice lawsuits will actually reduce premiums for those doctors. If we pass reforms with caps, we will be denying victims their rights to sue and recover damages for medical malpractice while at the same time passing those caps do nothing to help doctors.

Mr. Chairman, we have several charts which all, for some reason, are labeled Exhibit 1 that I am going to ask to have entered into the record of this hearing which show that, in States like California, when you put caps on medical malpractice damages, it absolutely did not reduce premiums. So I would ask unanimous consent to put those charts in, and I will be showing those later.

Mr. BILIRAKIS. Without objection.

[The information referred to follows:]

**INSERT OFFSET FOLIOS 1 TO 7 HERE**



Ms. DEGETTE. It is also ridiculous to address medical malpractice reform when we don't look at the cost of insurance and other factors in pricing of malpractice premiums. Among the contributors of rising malpractice premium costs are issues totally related to victim's compensation, the cyclical nature of the insurance business cycle, management or mismanagement of investments and reserves and even pressures health care financiers and the creation of restrictive delivery systems such as managed care have wrought. Managed care and the pressures that health care financiers place on providers share the blame in part because, as insurers and companies put pressure on physicians to reduce the amount of time they spend with patients as well as cut down on the number of referrals to specialists, mistakes are often made.

Focusing on damage caps as the height of malpractice reform ignores these and other issues acknowledged to be factors. I would like to say that many say, well, we are not capping noneconomic—we are not capping economic damages, we are only capping noneconomic damages. But in the case of Ms. Lewinski, in the case of stay-at-home moms, in the case of children, when you cap noneconomic damages to a proportion of economic damages you are leaving them with no compensation.

Now, in fact, I think this is your traditional congressional problem or solution in search of a problem. Because of all of the medical malpractice cases, 88 percent of patients did not sue when there was bona fide medical malpractice, 22 percent have sued, and the reason is because of patient-doctor relationships. So let's look at the real reasons this is going on.

Mr. Chairman, I do look forward to this hearing.

Mr. BILIRAKIS. I thank the gentlelady.

Mr. Upton.

Mr. UPTON. I have a statement for the record, and I defer.

Mr. BILIRAKIS. Let's see. Mr. Norwood.

Mr. NORWOOD. Thank you, Mr. Chairman. I would like to make an opening statement, please.

I thank you very much and the authors of this bill for bringing this critical legislation to us this morning. I think all of you are to be commended for your efforts.

This bill is before us today because we have a crisis in this country. Call it professional liability insurance, call it medical malpractice insurance, whatever you call it, the premiums providers pay for insurance are skyrocketing. The impact of these skyrocketing premiums are affecting access people have to health care. I think probably all can agree with that.

Now I understand that the reasons for the recent premium increases are very complex. I happen to believe we should examine the insurers' antitrust exemption. I do believe we should look at ways to make sure that investment losses don't create premium crisis. However, there is one area we can immediately address that can change the insurance market. We can limit the damages available to an injured patient. That will bring a much-needed stability to insurers, to the providers of health care and, ultimately, to premiums.

Is a \$250,000 limit on noneconomic damages the right amount? I am not sure it is. I can tell you I don't know what the right num-

ber is. I am certain, though, that there must be a number out there that we can agree upon that is reasonable and just.

We are not limiting recovery for economic damages in any way. We allow punitive damages to be as much as twice economic damages. But to say that there never can be any limit, any limit on noneconomic damages, no matter how high, is not a reasonable position to take today.

Mr. Chairman, this bill is about access, but it is also about defensive medicine and a lot of money that is being wasted in health care. If we don't address the issue of medical malpractice insurance, we run, in my opinion, the risk of jeopardizing the health of patients because they cannot get in to see a doctor when they need one. We can do without many lawyers, but since our health care facilities are stretched as thin as they are we really cannot afford to do without our physicians today.

It is of interest to me, I wonder, should we come to some reasonable limit, some reasonable number on noneconomic damages, might we have a lawyers' strike? Maybe that is not at all a bad idea. But a physicians' strike scares me to death.

I strongly encourage members to support this bill. It is like any other bill I ever voted for: I hate some of it, and I love some of it. Even my own bills I feel that same way about. But we are dealing with a crisis, and this is one of the ways we can help with the crisis, save money in health care by defensive medicine and make it reasonable so our physicians can protect themselves and their families and go about the business of treating patients.

Mr. Chairman, I yield back the balance of my time.

Mr. BILIRAKIS. The Chair thanks the gentleman.

Ms. Capps for 3 minutes.

Ms. CAPPS. I will submit a statement, and I will wait.

Mr. BILIRAKIS. So you will have 8 minutes.

Mr. Deal.

Mr. DEAL. I reserve my time, Mr. Chairman.

Mr. BILIRAKIS. You reserve your time. You also have 8 minutes. Let's see who is next here. Mr. Strickland.

Mr. STRICKLAND. I would defer at this time and keep my time for the questioning, sir.

Mr. BILIRAKIS. All right.

Mr. Shadegg.

Mr. SHADEGG. I reserve my time.

Mr. BILIRAKIS. Eight minutes.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. I will give my statement.

Mr. Chairman, I appreciate you holding this hearing on assessing the need for enactment of medical liability reform. This is an important topic, and it is correct it is a nationwide concern.

Without question, medical malpractice premiums have been increasing for physicians throughout our country, particularly in my home State of Texas. I have heard from many of my physicians who are experiencing significant increases in the premiums. These doctors have been serving patients in my area for decades and are being forced to decide whether they should keep practicing, restrict their service or move to another area.

The situation is unacceptable, and something must be done. But I am very wary of the Federal Government wading into this area of tort reform, an area that has traditionally been under the jurisdiction of States. In my experience in 20 years as a State legislator it has been dealt with in the State of California and even in my own State of Texas now with the legislature in session. There will be an issue, there will be a legislation to address this, because these medical malpractice lawsuits are typically only filed in State courts. That is where the States should be dealing with it.

To nationalize this type of issue, one, I think is asking for trouble. Because once Congress passes legislation, unlike our States who can change things very—fairly quickly, we do not. Are we going to force these cases to Federal courts? Are we going to provide Federal rules that our States have to live by? Which, again, I have a lot of elected State judges in Texas who have concerns about that.

My colleagues on the other side of the aisle cite the success of MICRA, the California experience; and there is a legitimate question on whether MICRA has, in fact, been successful in reducing medical malpractice premiums. But, again, we are looking at a successful case, if it is in California, but it is California who dealt with their issue.

I hope that we would as Members of Congress respect that the States can deal with it, the States are going to address it, and the States have addressed it, those States who have been in session.

I do have some concern about H.R. 5. I think it absolutely goes very much further than any medical malpractice. In fact, I am somewhat offended that if we are going to pass a medical malpractice reform for our physicians that we are also including HMOs, pharmaceutical manufacturers and medical device manufacturers. I think it is a sad day that we send out a doctor who is serving our patients as a smoke screen to be able to protect industries that really can stand on their own. If they need to have medical malpractice liability relief, then let them come on their own and not use our everyday physicians as a screen.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Buyer.

Mr. BUYER. I reserve.

Mr. BILIRAKIS. Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Chairman.

Several weeks ago in New Jersey thousands of physicians planned a work stop Statewide in response to skyrocketing insurance premiums. Although I sympathize with doctors, especially those in high-risk specialties such as obstetricians and other surgeons, I have to express that H.R. 5 is not the solution to the current medical malpractice crisis.

I have several concerns with this legislation. First of all, if we are here to address the issue of medical malpractice, I see no reason why the scope of H.R. 5 must include protections for a broad variety of medical participants including HMOs, nursing homes, nurses, doctors and drug and device manufacturers. This bill is not limited to medical malpractice, and I am astonished that provisions

in this bill protect manufacturers, distributors or suppliers of drugs or medical devices from punitive damages.

It seems to me that what we have here is a very political effort to not only mention medical malpractice but also try to deal with a lot of other types of tort reform or even product liability reform. I don't think that the public understands that no effort has really been made to reach out to the Democrats and do anything on a bipartisan basis and rather just ram something through that is going to go to the floor that probably has no chance of ever passing.

Additionally, I find the statute of limitations outlined in the bill to be unacceptable. In most States, the time allowed for statute of limitations does not usually begin until the harm or injury is discovered or reasonably should have been discovered. Moreover, for children, many State statute of limitations does not begin until the child turns 18. I am particularly concerned about this bill being detrimental to children. I have three children of my own. So it is very much of a concern to me.

Basically, what I think the authors are saying is that, if we have legislation that limits noneconomic damages to \$250,000, then the problem of medical malpractice premiums is simply going to go away. I don't buy that. It is a one-size-fits-all approach. It doesn't look at the actual underlying issue of health care and medical malpractice.

I think we have a major problem with insurance premiums. We have bad accounting or bad business judgment on the part of the insurance industry that hasn't been taken into consideration here.

What we should do is provide some kind of Federal reinsurance program. I have proposed that with H.R. 485, the Federal Medical Malpractice Insurance Stabilization Act.

I just want to say one more thing. I really don't think that the opportunity has been given today in terms of who is testifying here to really even have the option of understanding what the problem is all about.

I read in the papers yesterday about the Santillan family and this person, 17-year-old woman, named Jessica Santillan who lost her life on Saturday. This is a perfect example of someone whose representative should have been here testifying today. I don't know exactly why there isn't anyone here. I know they have asked to be here to have the opportunity to present testimony about why this legislation would not allow for a satisfactory outcome in a case like that. I think between the witnesses and the way the majority is going about this it is really not giving us an opportunity to learn what the root cause of this problem is.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Pitts.

Mr. PITTS. Thank you, Mr. Chairman, for holding this important hearing today. This is one issue on which we cannot afford to waste time. The situation in my State of Pennsylvania is dire. Pennsylvania hospitals and physicians face skyrocketing premiums, causing major insurers to drop coverage or raise premiums. It is ridiculous that in some cases the new premiums are more than the actual income a health care provider earns annually.

What this really means is that we have a serious problem—not just a serious problem, actually, it is a crisis—with access to care

in Pennsylvania. The continued deterioration of the medical liability market in Pennsylvania threatens the viability of hospitals, of health systems and physician practices.

Brandywine Hospital in my district was forced to close its trauma center in June of last year due to lack of trauma surgeons. And the CEO Allen Larson, who cited, quote, soaring medical malpractice premiums that are driving surgeons out of State or into retirement, close quote, said that he tried to recruit new trauma surgeons only to find that all Pennsylvania graduates of trauma surgery left the State to start practicing elsewhere. This means that severely injured patients must be transported to Philadelphia, almost an hour away, or other cities many miles away.

Chester County Hospital, another in my district, came very close to taking the drastic step of closing its maternity ward when insurance for obstetricians skyrocketed. The doctors reported that they would have to discontinue offering care at that hospital, and the hospital stepped in at the last minute with a temporary solution and actually put these independent physicians on their payroll in order to provide coverage for them through the hospital captive insurance company. Since Chester County Hospital does 2,100 or so deliveries a year, this load was too big for other providers in the area to pick up; and women would have to leave our county to have their babies.

Mr. Chairman, we will hear many arguments today from doctors and trial attorneys and insurance companies, but I hope we can see clearly through all of this to the bottom line: The current system is not working. Patients are being denied care because large numbers of physicians are leaving the State. And this is one case in which we need to have uniform minimum standards. Doctors should not have to choose where to live or work due to their malpractice insurance.

As you know, the Pennsylvania State legislature did pass legislation this year that included numerous tort reforms and some economic relief. However, the financial pressures created by the escalating medical liability crisis will not be resolved by these limited tort reforms. Passage of the health act is critical because it contains important reforms. Key among them is the establishment of a cap on noneconomic damages.

Let's be honest, at the end of the day, this legislation is not about doctors or insurance. It is about mothers having places to deliver their babies and accident victims having a nearby trauma center to go to.

I strongly support this legislation and look forward to hearing from our witnesses before us today. I yield back.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Ferguson.

Mr. FERGUSON. Thank you, Mr. Chairman. Appreciate you holding this hearing.

In New Jersey, where I am from, we are fortunate to have one of the greatest health care systems anywhere. We have top-notch hospitals. We have some the best doctors and nurses anywhere. We have some the best medical research anywhere in the world. Our medical professionals are devoted to their work and to the people that they serve. They serve on the front lines of our Nation's health

care system in a way that I think really exemplifies the best of the American spirit.

But in New Jersey today we face a perfect storm. The dramatic rise in lawsuits, coupled with the skyrocketing liability insurance costs for doctors and hospitals, they are jeopardizing patient care. If we don't take corrective action now, the situation is only going to become more severe. After all, without insurance, doctors can't practice. But high insurance costs are forcing many doctors in our State to abandon their practices. With too many frivolous lawsuits too many of our doctors are being forced to settle cases for large amounts of money, even when they haven't committed an error.

In New Jersey, in the year 2000, more than \$190 million was paid out to cover jury awards, a figure that put our State in the top ten in the Nation. These lawsuits have caused doctors' liability insurance premiums to mushroom and increased the cost of health care for all of us. Because premiums and lawsuits are threatening doctors in an unpredictable and unlimited manner, many doctors in New Jersey can't afford to get affordable insurance coverage at all.

What is most disheartening is that litigation fears not only increase the cost of health care but also have discouraged doctors from helping individuals who are most in need and who can't afford their services. Many doctors can't volunteer their services for patients who can't pay, and the proportion of physicians who provide any charity care at all has declined nationwide. This deprives patients of long-term, trusted relationships and sometimes leaves them without a doctor altogether.

My family, as many others, has personally experienced the effect of this crisis in New Jersey firsthand. Three weeks ago, my wife and I were blessed with our third child. My wife's due date was the very week of the job action that Mr. Pallone had referenced before. Over the last few months, we have seen many physicians leaving their practice; and in my wife's doctors OB/GYN practice my wife's doctor's partner left the State recently because of her insurance premiums. My wife's doctor's premiums went up 40 percent just this year.

While our physician gave us every guarantee that she would be there for us when the day came, and she was, there are fathers and mothers and loved ones who I fear for. I fear that the bond between patients and their doctors will be broke and that these patients will not have access to the trusted professionals because of the frivolous lawsuits and the resulting insurance premiums which are forcing doctors to abandon their practices.

There is no reason it has to be like this. It is simply not right when those physicians who want to provide their services are discouraged from doing so because of the fear of litigation. Patients should have their day in court, and this legislation allows patients to have their day in court. But the legislation also protects patients by preserving and not breaking the bond of the doctor-patient relationship.

I want to thank Mr. Greenwood for introducing this important legislation. I look forward to hearing the testimony from the witnesses today. Thank you.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Burr.

Mr. BURR. Thank you, Mr. Chairman.

Let me take this opportunity to thank our witnesses here today. I am sorry we couldn't provide better weather for you, and hopefully you won't get stuck here.

Let me respond to something that was said earlier. I have worked very successfully with people on the other side of the aisle to produce health care legislation with those individuals who look for solutions, and I look across the aisle today with the same intent and with the previous history with them of one of accomplishment. I also make no bones about the fact that I choose not to work with those on the other side of the aisle or on my side of the aisle that choose to use this only for political purposes. Because we have reached the point in health care where we need answers, and we need answers now.

After working on health care for now 8 years, I am well aware of the complexity of the health care delivery system. Some people today are going to say that enacting Federal medical malpractice reform is not going to help our health care delivery system. Other people are going to say that this legislation will serve two important purposes: first, that it will decrease health care costs through reductions in the malpractice insurance premiums; and, second, it is a positive step toward reigning in a litigious society.

If it were up to me, the debate on this issue would be a looser pay system where we take a much bigger bite at getting at the frivolous lawsuits that I think have become prevalent in society. It is somewhat ironic to me that the same individuals that criticize us being here debating this and proposing this legislation today are in fact the ones that use the argument on other health care issues that it is doctors, it is hospitals, it is nurses, it is health professionals who we should empower to make more decisions.

It is not insurance companies and so on, but it is health care professionals that should be empowered to play a bigger role in the health care solution in this country. In fact, it is doctors and hospitals and nurses and health care professionals that have over and over and over again said to us that the first thing we need to do to try to curb the inflation cost in health care is reign in the lawsuits that are currently taking place. We are attacking exactly the place that health care professionals have said is the first place we need to go.

There is no question in my mind that this legislation will help our health care system. As long as medical malpractice premiums continue to increase, our overall health care costs will increase. I want patients to have the access to high-quality and reasonably priced health care and, yes, to have the right to pursue when harmed. I think we have protected that.

I urge my colleagues to support Representative Greenwood; and I yield back, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Pickering.

Mr. PICKERING. Mr. Chairman, thank you for this very important hearing.

As we look at Medicare, Medicaid, veterans' health care, prescription drugs, the delivery of health care, rural health care, health care in States like mine in Mississippi which over the past

few years has been in a State of crisis and we look at our responsibilities as a committee and as a Congress as to how do we have a comprehensive health care policy for our country that we have access to insurance for the individuals that are providers can practice without the fear of being bankrupted by an excessive jury verdict, what can we do to contain the cost, make health care available to all Americans and my State of all Mississippians?

This is a very important piece, a very important part, a very important component of a comprehensive health care policy.

Later this year, we will be working on Medicare reforms. We will be working on a prescription drug benefit. The Veterans Committee will be looking at what they have to do to get veterans' health care. If we look at all components, this issue about out-of-control lawsuits and the cost increase that is put into every system and every place and every community, because of it we have to act on this piece of it just as we have to act on all those other things.

I want to join with Congressman Burr. In my home State of Mississippi, a bipartisan compromise was reached this past year, legislation was passed, and we believe that it will make a significant difference in our State.

Now the caps in the State legislature and Mississippi that were passed were higher than the caps passed in this legislation, a \$500,000 cap on noneconomic damages, and then over time it would increase with inflation, \$750,000 cap by 2011, \$1 million by 2017. It is a reasonable and a common-sense approach to solving the problem in Mississippi.

I hope the same type of common-sense approach, bipartisan approach can be found here in Congress. As we look at overall health care, we have to have this piece as part of our strategy and part of our policy to be able to make health care affordable and available and at a high quality to all Americans.

So, Mr. Chairman, I look forward to working with you on this and hope that we can find a way to find a common ground and consensus just as we did in Mississippi this past year.

Mr. BILIRAKIS. I thank the gentleman.

I believe that takes care of all the opening statements. As we said earlier, any written opening statements could be made a part of the record.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, I commend you for holding today's hearing to assess the need to enact medical liability reform to address the growing malpractice insurance crisis affecting physicians, hospitals, and other health care providers in many states and address some of the factors fueling the double-digit increases in health care premiums with which large and small employers and individuals and families across the nation are grappling.

My state of Michigan has already put in place a number of the important reforms similar to the federal reforms we are contemplating. As a result, Michigan is not experiencing the malpractice insurance crisis that is gripping many other states. But we are certainly not immune from such experiences as sharp increases in premiums and insurers withdrawing from our market. Last year, for example, the emergency physician group serving one of the largest hospitals in my district almost lost its malpractice insurance. Had help not come at the very last minute, an entire community could have lost access to emergency care. Similarly, a large physician practice serving the poor and uninsured in Southwest Michigan could not afford to



renew its malpractice insurance policy because of a sharp increase in the premium. They were eventually able to find more affordable insurance, but only by increasing their exposure.

While I have thus been very supportive of federal medical liability reform, I hope that as this process moves along, we will be mindful one potential problem that a federal pre-emption of certain state laws could pose for physicians. Specifically, many Michigan physicians are concerned that by pre-empting our state joint-and-several liability provision and replacing it with a "fair share" provision, they may face higher malpractice liability insurance premiums and be forced to purchase considerably more coverage than they now typically carry. I hope that during the course of these hearings, we can explore these concerns.

Again, Mr. Chairman, thank you for your leadership on medical liability reform. I look forward to working with you again this year as we seek to address this issue that is critical to continued access to affordable, community-based care across Michigan and our nation.

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PREPARED STATEMENT OF HON. STEVE BUYER, A REPRESENTATIVE IN CONGRESS  
FROM THE STATE OF INDIANA

Mr. Chairman. Thank you for bringing this measure, H.R. 5, before the Subcommittee. This is timely legislation to ensure that our constituents have access to health care.

H.R. 5 strikes an appropriate and reasonable balance between the need for patients who have been harmed to seek redress and the need of all patients to have access to health care services.

The State of Indiana has been at the forefront of ensuring an effective medical liability system. More than 20 years ago, the State of Indiana enacted reform to its medical liability system. This system has served the State and its citizens very well and has served as a model for other States, including the State of our fine full Committee Chairman.

Nothing in the legislation we are moving today would inhibit Indiana from keeping its current medical liability system. In Indiana, a medical review panel is convened to review the validity of the medical claims in the case. Indiana law places limits on the liability of health care providers. Recovery over this limit is provided by a compensation fund managed by the State. Total recovery is capped and attorneys' fees are capped. Injured patients receive compensation in a timely fashion.

It is my understanding that under the intent of H.R. 5, Indiana will be able to retain the core aspects of its medical liability system. These include, the medical review panel requirement, the total compensation cap, and the limits on providers' liability. It is also my understanding that, should this legislation be enacted, other States could follow Indiana's lead and adopt similar reform to their systems.

With these understandings, Mr. Chairman, I urge that the Subcommittee move this legislation forward.

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PREPARED STATEMENT OF HON. ERNIE FLETCHER, A REPRESENTATIVE IN CONGRESS  
FROM THE STATE OF OKLAHOMA

Mr. Chairman, thank you for conducting this hearing today. As a physician, I have always tried to do what is best for my patients. As a Member of Congress, I still try to do what is best for patients in Kentucky and across America.

I hear stories about women who have to drive 75 miles or more to have their babies delivered and end up delivering in their cars, because their doctor quit delivering babies or the nearby maternal wards have closed due to out of control medical liability premiums.

What is best for the patient? I believe that unlimited medical liability awards are bad for patients, because they cause malpractice insurance prices to climb, resulting in more expensive care, fewer doctors, and an access to care problem. Trial lawyers argue that limiting awards is bad for patients because it means that the most serious injuries aren't properly compensated. However, H.R. 5, the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003, which I support, actually ensures fair compensation for everyone. We need to keep in mind that everyone is entitled to full compensation for their actual losses, medical bills and wages under H.R. 5. This is very fair.

Punitive damages under the HEALTH Act would be two times economic damages—which are not capped, or \$250,000, whichever is greater. Punitive damages are meant to send a message, not to compensate the victims. Unfortunately, trial

lawyers have been winning outlandish punitive damage awards—mainly for themselves—at the expense of the patients, providers, and all Americans.

It's not unusual to hear stories of doctors moving from Kentucky to Indiana or from Nevada to California to take advantage of the lower cost of medical liability insurance. Passing H.R. 5, the HEALTH Act, which reasonably reforms our liability system, will enable insurers to hold premiums at a lower, more constant rate without arbitrarily setting price controls on premiums that further exacerbate the access to care problem we face.

We will hear today from some who do not support comprehensive liability reform, claiming that it is the stock market's fault that we are seeing malpractice liability premiums rising. Yet the stock market hit the insurers in Kentucky and Nevada as much as they did in California and Indiana. Furthermore, insurance rates did not jump in states like California in the past couple of years, as they did in Nevada, Pennsylvania, and West Virginia. Having a reasonable limit on pain and suffering, which is unquantifiable, and other reforms in H.R. 5 will help improve the current unhealthy cycle, which trial lawyers are currently perpetuating.

Lawsuits are a poor answer to medical events. They don't prevent injuries and they don't reduce medical errors. But they do create an atmosphere of fear, defensiveness, and distrust in the physician-patient relationship. As a physician, I took an oath "to do no harm." The only bill today that will help physicians to keep that oath is one that safeguards safe and timely access to care through reasonable, comprehensive and effective health care liability reform, and H.R. 5 does just that.

The rapid escalation in medical malpractice awards and the resulting rise in medical liability premiums are major problems that demand action now. It affects patients' access to quality care, especially women and patients in rural areas. It is clear that these excessive awards are driving the cost of health care up, which is a major concern for most Kentuckians and Americans. Legislation must be passed to control this critical problem both at the state and federal levels. I have strongly supported previous attempts to pass reform and will continue to support passage of significant medical liability reform.

Mr. BILIRAKIS. We will go right now to the panel. I want to welcome all of you.

Ms. Heather Lewinsky is, I know, from the Pittsburgh area or that is an address, the Buffalo. But we thank her for her courage in wanting to come here. There is nothing to be afraid of.

Mr. Jim Hurley is here on behalf of the American Academy of Actuaries; Mr. Heistand is CEO and General Counsel for Californians Allied for Patient Protection; Mr. Rosenfield is the President of the Foundation for Consumer and Taxpayer Rights; Ms. Rosenbaum is Hirsch Professor of Health Law and Policy at G.W.; Mr. Lawrence C. Smarr is President of Physicians Insurance Association of America; and Dr. Donald J. Palmisano is President of the American Medical Association.

Again, welcome. I am going to set the clock to 5 minutes, and your written statement is already a part of the record so we would hope that you complement it more than anything else.

Ms. Lewinski, please proceed when you are ready.

**STATEMENTS OF HEATHER LEWINSKI; JAMES HURLEY, ON BEHALF OF THE AMERICAN ACADEMY OF ACTUARIES; FRED J. HIESTAND, CEO AND GENERAL COUNSEL, CALIFORNIANS ALLIED FOR PATIENT PROTECTION; HARVEY ROSENFELD, PRESIDENT, FOUNDATION FOR CONSUMER AND TAXPAYER RIGHTS; SARA ROSENBAUM, HIRSCH PROFESSOR OF HEALTH LAW AND POLICY, GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER, SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES; LAWRENCE E. SMARR, PRESIDENT, PHYSICIANS INSURERS ASSOCIATION OF AMERICA; AND DONALD J. PALMISANO, PRESIDENT, AMERICAN MEDICAL ASSOCIATION**

Ms. LEWINSKI. My name is Heather Lewinski. I am a 17-year-old high school senior. I recently saw President Bush on television saying that Congress should pass a law saying that doctors or hospitals who injure people through their medical mistakes should never have to pay the patients more than \$250,000 for their pain and suffering. I do not believe that doctors should be blamed for everything bad that happens to a patient, but if they make a mistake the patient's pain and suffering can be way more than \$250,000. Unfortunately, I know this from personal experience.

When I was 8 years old, a doctor performed a surgery on my face that never should have been done. He told my parents that he had tried this surgery successfully on many other patients with my condition, but my parents and I later found out that that was not true. This doctor had never done the surgery before; and, in fact, we were told that no doctor in the whole United States had ever recommended this surgery for a condition like mine. I feel like the doctor was using me as a guinea pig.

The doctor told my parents that he would be able to take care of my problem with two easy surgeries a few months apart. He also told my parents that I would have no visible scars. I wish that doctor had just told the truth. I ended up with horrible scars all over my face, and I have gone through 14 major surgeries on my face to try to correct what he did. I have had so much pain over the past 10 years I can't even begin to tell you about all of it.

I never had any surgery before this doctor operated on me, so I never knew what to expect. After I went through the first surgery, I had so much pain like I had never felt before. Since then, it has never gotten better with any of my surgeries and in addition has instilled a horrible fear. Every time one of my surgeries is approaching I would get frightened and always thinking about the surgery and the pain I would be in. It would get so bad that I actually would have to sleep with my mother for many nights before the surgery. That went on with all of my operations, and it did not matter whether I was 9 or 13 or 14 years old. This makes me feel stupid. Here I am a teenager, but I end up sleeping with my mom because I am so afraid of surgery, the hospital and everything that goes with it.

After every surgery I had I would be forced to stay in the hospital for awhile. Then when I go home where I would be in bed or on the sofa for weeks. My mouth would be wired shut. My face would be swollen. My entire head would be wrapped in bandages. Sometimes the pain was so bad it would feel like my whole face

was going to explode. It was like someone had a hammer and kept hitting me.

I remember 1 day we were driving to the hospital for one of my surgeries, and it was around Christmas time. There was a song on the radio called, It's a Marshmallow World. I started to cry, and I said to myself, it really isn't a marshmallow world.

I will never forget the first time I looked at my face after surgery. The doctor told us that I wouldn't have any noticeable scars. I took the bandages off my face and looked in the mirror and just cried. I could not believe what he had done to my face. He tried to do another surgery to fix it, but that only made things worse. I not only had these thick red scars all over my face but now the corner of my mouth was all pulled down. I looked like I had a stroke.

After all of my surgeries, my face and my whole body would hurt so bad. I wanted to hide away because I did not want anyone to see me. My appearance was so gruesome that no one should have to see me.

From third grade through 8th grade, I missed so much school from all the surgeries that I had trouble keeping up. In third grade, I missed from March until the end of the year. In fourth grade, I missed from Thanksgiving break until the rest of the school year. In fifth, sixth, seventh, and eighth grades, I missed anywhere from 3 to 5 months of school each year. I had to have tutors and be home schooled all this time. I remember that even though I have always been a good student they had to label me "special ed" because I missed so much time. I hated that label.

I still cannot believe I have gone through 14 surgeries. You never get used to the pain, and the fear never goes away. But by far the worst the part about everything that has happened to me is the way my face looks and how people treat me. I wish people could see the inside of me and know the kind of person I really am, but all they see is those scars on my face, and they stare. From third grade until now, every time I walk into the halls or into class or in the cafeteria people are staring. The kids in school constantly tease me and called me names like Two Face, the character from the Batman movie. I hated to eat in the cafeteria because I could not close my mouth, and I would drool. Because of the corner of my mouth, the way my mouth looked, the kids would walk around school and pull down their lip and mock me like they had a stroke.

I hate to go out in public because adults stare, and some of them even come up to me and ask questions. I remember once being in an ice cream parlor with my family, and there was a lady with her son, and she just kept pointing to my face and then talking to her son. This sort of thing happens to me all the time.

I really like people, but I have only one close friend, my girlfriend Angela who I grew up with. It is so hard for me to meet new people and make friends because they just stare. And even a few other kids who are supposedly my friends at school will not walk with me in the halls, and it seems like they are always two to three steps behind me. I quit riding the bus from school a long time ago because it was torture. My mom has to take me to school and pick me up.

Sometimes I wish so hard that there was some magic that I could just make myself invisible to other people and still be able to enjoy them.

I am now a high school senior, and I have never had a boy ask me on a date. I will be 18 in a few months, and I have never kissed a boy. I remember one time sitting in the cafeteria a few years ago, and a boy came up to me and asked me if I was doing anything on Friday. I was so excited that I almost fell over, but then he went back to his table with his friends, and they started laughing and pointing at me, and I realized it was just a joke.

The only school dance I ever attended was in ninth grade. It was a Valentine's Day dance, and I wanted to go so bad, but no one asked me. I finally asked out a boy that lives next to me if he would go, and he was so nice that he could not say no. I was so excited, and my parents really bought me the works—a new dress, new shoes, makeup, hair. My dad told me I looked like a princess, and I just remember looking in the mirror and seeing my face and hoping that the boy would not be looking at my scars.

I have never really been involved in school activities because I just do not have that many friends. The one activity that I have that I really love is training and showing dogs. I have been doing that for a few years. Other people hire me to train and show their dog, and I also train and show my own dogs. I usually compete in dog shows on the weekends in New York and some other States. I have been really lucky and have been able to win several awards competing against adults at the dog shows. I think one of the reasons that I like dog training so much is that animals can't stare or laugh at you.

I will be graduating from high school on time in a few months, and I have already been accepted into college. Because of my fears of meeting new people. I chose a college that is close to my house so I do not have to stay in a dorm with other kids.

My biggest wish is that someday I will find a boy who will look at and see me for what is on the inside of my heart and my mind and not my appearance. I would love to get married and have a family some day, but if I am honest with myself I do not know that that will ever happen, so I have made other plans. I will finish college and become a kindergarten teacher. I have always loved baby-sitting kids and being around them. Little children do not stare so much, and they just accept you for what is inside. I will teach school and live in the country with lots of dogs, and I will be self-sufficient.

I know that the President is trying to make good decisions, but if he could see everything that I have gone through for the last 10 years and everything that I am going to go through for the rest of my life, I think he would realize that he is wrong about this law and that every patient is entitled to be judged as an individual based on what they have gone through.

I think that most doctors try to do the best they can for people. But sometimes they do things that should not be done. And when that happens, I think she should be responsible for all the harm they cause and not just part of it. I know that nothing could be done to change what has happened to me. But I hope that if we keep the laws strong, maybe a doctor will be more careful in the

future and no other little girl will have to go through what I have. Thank you.

[The prepared statement of Heather Lewinski follows:]

PREPARED STATEMENT OF HEATHER LEWINSKI

My name is Heather Lewinski. I am a 17-year-old high school senior. I recently saw President Bush on television saying that Congress should pass a law saying that doctors or hospitals who injure people through their medical mistakes should never have to pay the patients more than \$250,000 for their pain and suffering. I do not believe that doctors should be blamed for everything bad that happens to a patient, but if they make a mistake, the patient's pain and suffering can be way more than \$250,000. Unfortunately, I know this from personal experience.

When I was 8 years old, a doctor performed a surgery on my face that never should have been done. He told my parents that he had tried this surgery successfully on many other patients with my condition, but my parents and I later found out that was not true. This doctor had never done the surgery before and, in fact, we were told that no doctor in the whole United States had ever recommended this surgery for a condition like mine. I feel like the doctor was using me as a guinea pig!

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After every surgery I had, I would be forced to stay in the hospital for a while. Then when I go home where I would be in bed or on the sofa for weeks and weeks. My mouth would be wired shut. My face would be swollen; my entire head would be wrapped in bandages. Sometimes the pain was so bad it would feel like my whole face was going to explode. It was like someone had a hammer and kept hitting me and hitting me.

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I still cannot believe I have gone through 14 surgeries. You never get used to the pain, and the fear never goes away. But by far the worst part about everything that has happened to me is the way my face looks and how people treat me. I wish people could see the inside of me and know the kind of person I really am, but all they

see is those scars on my face, and they stare and glare at me. From third grade until now, every time I walk in the halls or into class or in the cafeteria, people are staring, and I hate it! The kids in school have constantly teased me and called me names like "Two Face," the character from the Batman movie. I hated to eat in the cafeteria because I could not close my mouth, and I would drool profusely. Because of the way the corner of my mouth looked, the kids would walk around school and pull down their lip and mock me like they had a stroke.

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The only school dance I ever attended was in 9th grade. It was the Valentine's Day dance, and I wanted to go so bad, but no one asked me. I finally asked our a boy that lives next to me if he would go with me, and he was so nice that he could not say no. I was so excited and my parents really bought me the works—a new dress, new shoes, make up, hair. My dad told me that I looked like a princess, and then I just remember looking in the mirror and seeing my face and hoping that the boy would not be looking at my scars.

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I know that the President is trying to make good decisions, but if he could see everything that I have gone through for the last ten years and everything that I am going to go through for the rest of my life, I think he would realize that he is wrong about this law and that every patient is entitled to be judged as an individual based on what they have gone through. I think that most doctors try to do the best they can for people, but sometimes they do things that should not be done, and when that happens, I think they should be responsible for all of the harm they cause and not just part of it.

I know that nothing can be done to change what happened to me, but I hope that if we keep the laws strong maybe a doctor will be more careful in the future and no other little girl will have to go through what I have.

Thank you very much.

Mr. BILIRAKIS. Thank you, Heather, and you are going to be a tough act for anyone to follow.

But Mr. Hurley is next.

**STATEMENT OF JAMES HURLEY**

Mr. HURLEY. It is indeed a tough act to follow. Chairman Bilirakis, Ranking Member Brown and members of the subcommittee, thank you for inviting me to testify today on behalf of the American Academy of Actuaries. The Academy is the public policy and professionalism organization for actuaries practicing in all specialties within the United States. The Academy is nonpartisan and assists the public policy process through the presentation of clear and objective actuarial analysis. The Academy also develops and upholds actuarial standards of conduct qualification and practice. For those not familiar with actuaries, actuaries collect and evaluate loss and exposure data to advise about rates to be charged for prospective coverage and reserve liability to be carried related to coverage already provided.

The Academy appreciates this opportunity to comment on issues related to the availability and pricing of medical malpractice insurance. In the time available, I would like to highlight a few key points from my written statement. I will start by discussing recent experience in the medical malpractice line of business. During the 1990's, the medical malpractice line experienced favorable operating results. This was contributed to by favorable reserve development on prior coverage years and healthy investment returns. Insurers competed aggressively. Health care providers shared in the benefit of improved loss experience and higher levels of investment income through stable or decreasing charged premiums.

Recently, however, the cost of medical malpractice insurance has been rising. Rate increases have been precipitated in part by the growing size of claims, more frequent claims in some areas and higher defense costs. The decline in expected future bond yields exacerbates the need for rate increases. From a financial standpoint, medical malpractice results deteriorated for the 3 years ending 2001. 2002 data is not yet available, but is projected to reflect similar results.

Two indicators of financial results are the combined ratio and the operating ratio. We can obtain these indicators or reporting from AM Best Company, a company that offers comprehensive data to insurance professional and tracks these results. The combined ratio is an indication about how the company is doing in its insurance underwriting. For all companies reporting to AM Best, the combined ratio of 130 percent and 134 percent for 1999 and 2000 respectively, deteriorated to 153 percent for 2001. For underwriting this represents a loss of 53 cents on each dollar of premium written in 2001.

Preliminary projections for 2002 are for a combined ratio of just under 140 percent. A measure of the overall profitability of insurers is the operating ratio. The AM Best operating ratio adjusts the combined ratio for other expense and income items primarily investment income but it is before Federal income tax. The operating ratio for 1999/2000 was approximately 106 percent indicating a net loss of six cents on every dollar of premium. This deteriorated to 134 percent in 2001, indicating a loss of 34 cents on every dollar of premium. Given lower interest income, the 2002 operating ratio will probably not improve as much as the projected improvement in the combined ratio. At these levels, 2001 and 2002 results are



the worst they have been in 15 years or more, approximating levels of the 1980's.

This data is clear. Today the loss in operating environment has deteriorated. Benefits of favorable reserve development appear to be gone and the available investment income offset has declined. In fact, some see that the reserve liabilities may require increases to cover current ultimate loss obligations. As a result, rates for both insurers and reinsurers need to increase to properly align with current loss and investment income levels. Companies failing to do this jeopardize their surplus base and their financial health. My written statement summarizes the two key drivers of financial results and their effects on operating results and surplus for some 30 companies specializing in this coverage. These companies represent about one third of the companies reporting to AM Best. The results for these companies are more favorable than the overall industry, but reflect similar deterioration.

In chart B on page 6 of my testimony, the total after-tax operating income for these companies is shown. The favorable operating income of the earlier years in the 20 percent neighborhood declines to a slight profit in 2000 and to a 10 percent loss in 2001. Regarding the impact on surplus chart E on page 8 of my testimony demonstrates the change in surplus from year to year for these same companies. Surplus increased through 1999 but at a decreasing rate. Importantly however, surplus declined in 2000 and more significantly in 2001. This is important because surplus represents the capital base for these insurers. Its decline reduces capacity to write new or renewing business prospectively and lessens insurers ability to absorb any adverse development on business written in prior years.

This, coupled with voluntary and involuntary withdrawals, for example, Saint Paul, MIIX, reciprocal of America has contributed to availability problems in addition to affordability problems. Companies continuing to write medical malpractice insurance must interpret the current experience and determine what rates to charge for prospective coverage. In addition, tort reform is discussed as one means to address the current challenges. The Academy, which takes no position for or against tort reform, has previously reviewed and commented on this subject. These observations include, one, a package that performs is more likely than individual reforms to affect losses and premiums.

Two, key among reforms is a per medical injury non-economic cap at a relatively low level and mandatory collateral source rule.

Three, poorly crafted reforms can actually increase losses and therefore rates.

Four, we must have reasonable expectations. Reforms may not yield immediate rate reductions, particularly given the rate increases being implemented today, since the actual effect including judicial confirmation will not be immediately known. Such reforms do not affect the economic components of the claim costs, and thus severity will still likely drive the need for increases in the future, but perhaps at some lower level. Such reform should make the loss environment more predictable, encourage market participation and reduce concerns of insurers about large subjective non economic damage components to claims.

In closing, I should comment on some frequent misconceptions. One misconception is that companies are increasing rates to recoup stock market losses. This is not true. The rate making process is forward looking and does not reflect loadings for past pricing inadequacy or past investment losses. It reflects expectations of future loss costs and on the investment side primarily prospective interest yields. In general, when prospective bond yields decline, rates will increase, all else being equal. Additionally, rates and investments are subject to regulatory oversight in most States. A second misconception is that companies cause the current problems. Medical malpractice is difficult to price and underwrite successfully which is, in part, why companies specializing in the coverage dominate it. Companies made decisions in the mid to late 1990's expecting continuation of recent stable——

Mr. BILIRAKIS. Please finish up, would you, sir.

Mr. HURLEY. Yes, sir. Unfortunately, the environment changed and loss costs increased, favorable reserve development ceased and investment yields declined and reinsurance costs jumped. This caused rates that need to increase. The Academy and I appreciate the opportunity to provide an actuarial perspective to these important issues, and we will be glad to provide the subcommittee with any additional information that would be helpful in your deliberation.

Mr. BILIRAKIS. Thank you. Thank you, sir. I am sure we will give you an opportunity during the inquiry to finish up.

[The prepared statement of James Hurley follows:]

PREPARED STATEMENT OF JAMES HURLEY, CHAIRPERSON, MEDICAL MALPRACTICE  
SUBCOMMITTEE, AMERICAN ACADEMY OF ACTUARIES

#### INTRODUCTION

The American Academy of Actuaries appreciates the opportunity to provide comments on issues related to patient access to health care and, in particular, the availability and pricing of medical malpractice insurance. The Academy hopes these comments will be helpful as Congress considers related proposals.

This testimony discusses what has happened to medical malpractice financial results and its likely effect on rates, tort reform, and some discussion of frequent misconceptions.

#### MEDICAL MALPRACTICE—WHAT HAS HAPPENED?

The medical malpractice insurance marketplace is in serious turmoil after an extended period of reported of high profitability and competitiveness during the 1990s. This turmoil began with serious deterioration in financial results, continued with some consequences of these results and, at least at this point, gives rise to an uncertain future. Industry-wide financial results reflect a 2001 combined ratio (the measure of how much of a premium dollar is dedicated to paying insurance costs of the company in a calendar year) that reached 153 percent and an operating ratio (reducing the combined ratio for investment income) of about 135 percent; the worst results since separate tracking of this line of business began in 1976. Projections for 2002 are for a lower combined ratio of approximately 140 percent and probable lesser improvement in the operating ratio. This follows 1999 and 2000 operating ratios of 106 percent.

The consequences of these poor financial results are several. Insurers have voluntarily withdrawn from medical malpractice insurance (e.g., St. Paul, writer of approximately nine percent of total medical malpractice insurance premium in 2000) or have selectively withdrawn from certain marketplaces or segments of medical malpractice insurance. In addition, several insurers have entirely withdrawn due to poor financial results (e.g., Phico, MIIX, Frontier, Reciprocal of America, some of which are under regulatory supervision). Overall, premium capacity has been reduced by more than 15 percent. These withdrawals fall unevenly across the states

and generally affect those identified as jurisdictions with serious problems more severely than others.

Capacity to write business would have decreased even more if not for the fact that much medical malpractice coverage is written by companies specializing in this coverage, some of whom were formed for this specific purpose.

The future outlook is not positive, at least in the short term. Claim costs are increasing more rapidly now than they were previously. Further, the lower interest rate environment would require higher premium rates, even if losses were not increasing. The combined effect is that there are likely to be more poor financial results and additional rate increases.

#### *Background*

Today's premium increases are hard to understand without considering the experiences of the last decade. Rates during this time period often stayed the same or decreased relative to the beginning of the period due to several of the following factors:

- **Favorable Reserve Development**—Ultimate losses for coverage years in the late 1980s and early 1990s have developed more favorably than originally projected. Evidence of this emerged gradually over a period of years as claims settled. When loss reserves for prior years were reduced, income was contributed to the current calendar years, improving financial results (i.e., the combined and operating ratios). That was the pattern during the middle to late 1990s for 30 provider-owned medical malpractice insurers whose results are shown in Chart A. What is evident from that chart is that favorable reserve development (shown as a percentage of premium) was no longer a significant factor in 2001 for these insurers as the effect approached zero. In contrast to the experience of these provider-owned insurers, the prior-year reserves for the total medical malpractice line of business actually deteriorated in 2000 and in 2001.
- **Low Level of Loss Trend**—The annual change in the cost of claims (frequency and severity) through most of the 1990s was lower than expected by insurers, varying from state to state and by provider type. This coincided with historically low medical inflation and may have benefited from the effect of tort reforms of the 1980s. Rates established earlier anticipated higher loss trends and were able to cover these lower loss trends to a point. As a result, rate increases were uncommon and there were reductions in several states. This was justified in part because the rates established at the beginning of the last decade proved too high, inasmuch as carriers had assumed higher loss trends.  
Insurers responded to the emerging favorable loss trend in different ways. Some held rates stable and paid policyholder dividends or gave premium discounts. Some reduced filed rates. Others increased rates modestly and tried to refine pricing models to improve overall program equity. In general, however, premium adequacy declined in this period. Collected rates came into line with insurers' costs, but competitive actions pushed rates even lower, particularly in some jurisdictions.
- **High Investment Yields**—During the 1990s, investment returns produced a real spread between fixed income rates of return and economic inflation. Counter to what some may believe, medical malpractice investment results are based on a portfolio that is dominated by bonds with stock investments representing a minority of the portfolio. Although medical malpractice insurers had only a modest holding of stocks, capital gains on stocks also helped improve overall financial results. These gains improved both the investment income ratio and the operating ratio.
- **Reinsurers Helped**—Many medical malpractice insurers are not large enough to take on the risks inherent in this line of insurance on their own. The additional capacity provided by reinsurers allows for greater availability of medical malpractice. Similar to what was happening in the primary market, reinsurers reduced rates and covered more exposure, making the net results even better.
- **Insurers Expanded Into New Markets**—Given the financial results of the early-to-mid-1990s, some insurers expanded into new markets (often with limited information to develop rates). They also became more competitive in existing markets, offering more generous premium discounts. Both actions tended to push rates down.

#### *What Has Changed?*

Although these factors contributed to the profitability of medical malpractice insurance in the 1990s, they also paved the way for the changes that began at the end of the decade.

- **Loss Trend Began to Worsen**—Loss cost trends, particularly claim severity, started to increase toward the latter part of the 1990s. The number of large claims increased, but even losses adjusted to eliminate the distortions of very large claims began to deteriorate. This contributed to indicated rate increases in many states.
- **Loss Reserves Became Suspect**—As of year-end 2001, aggregate loss reserve levels for the industry are considered suspect. Reserve reductions seem to have run their course. As mentioned earlier, the total medical malpractice insurance industry increased reserves for prior coverage year losses in 2000 and 2001, although results vary on a company-by-company basis. Some observers suggest that aggregate reserves will require further increases, particularly if severity trends continue or intensify.
- **Investment Results Have Worsened**—Bond yields have declined and stock values are down from 1990s highs. The lower bond yields reduce the amount of expected investment earnings on a future policy that can be used to reduce prospective rates. A one percent drop in interest rates can be translated to a premium rate increase of two to four percent (assuming no changes in other rate components) due to the several year delay in paying losses on average. A 2.5 percent drop in interest rates, which has occurred since 2000, can translate into rate increases of between 5 percent and 10 percent. Note that this factor may discourage an insurer from maintaining market presence and also may discourage new entrants.
- **The Reinsurance Market Has hardened**—Reinsurers' experience deteriorated as their results were affected by increased claim severity and pricing changes earlier in the decade. Because reinsurers generally cover the higher layers of losses, their results are disproportionately influenced by increases in claim severity. This, coupled with the broadly tightened reinsurance market after Sept. 11, has caused reinsurers to raise rates substantially and tighten reinsurance terms for medical malpractice.

The bottom line is that these changes require insurers to increase rates if they are to preserve their financial health and honor future claim payments.

#### *The Results*

To obtain a better understanding of the effect of these changing conditions, we focus on the results of 30 specialty insurers that are primarily physician owned or operated and that write primarily medical malpractice business. Their results reflect the dynamics of the medical malpractice line. This sample represents about one-third of the insured exposures in the United States.

These insurers, achieving more favorable financial results than that of the total industry, showed a slight operating profit (four percent of premiums) in 2000. This deteriorated to a 10-percent operating loss in 2001 (see Chart B).

There are two key drivers of these financial results:

- **Insurance Underwriting**—For these companies, a simplified combined ratio was calculated by dividing calendar year loss and loss adjustment and underwriting expenses by premium. The combined ratios were 124 percent and 138 percent in 2000 and 2001, respectively. That means in 2001, these insurers incurred \$1.38 in losses and expenses for each \$1.00 of premium. The preceding five years were fairly stable, from 110 percent to 115 percent. Deterioration of the loss and loss adjustment expense ratio drove these results; the underwriting expense ratio remained relatively constant (see Chart C).
- **Investment Income**—Pre-tax investment income (including realized capital gains and losses) derives from policyholder-supplied funds invested until losses are paid as well as from the company capital ("surplus"). The ability of investment income to offset some of the underwriting loss is measured as a percentage of earned premiums. This statistic declined during the measurement period from the mid-40 percent to the mid-30 percent level and, in 2001, to 31 percent (see Chart D).

This offset will continue to decline because (i) most insurer-invested assets are bonds, many of which were purchased before recent lower yields, and interest earnings do not yet fully reflect these lower yields; and (ii) the premium base is growing due to increased rates and growth in exposure. Invested assets are not increasing as rapidly as premium and, therefore, investment income as a percentage of premium will decline.

The effect of these results on surplus is reflected in Chart E, which shows the percent change in surplus from one year to the next. Surplus defines an insurer's capacity to write business prospectively and to absorb potential adverse loss development on business written in prior years (see Chart E).

### *Tort Reform*

Some states enacted tort reform legislation after previous crises as a compromise between affordable health care and an individual's right to seek recompense. The best known is the Medical Injury Compensation Reform Act or MICRA, California's tort reform package. Since MICRA's implementation in 1975, California has experienced a more stable marketplace and lower premium increases than have most other states.

Tort reform has been proposed as a solution to higher loss costs and surging rates. Many are suggesting reforms modeled after California's MICRA, although some have cautioned against modifying the MICRA package. The Academy, which takes no position for or against tort reforms, has previously reviewed and commented on this subject. Based on research underlying the issue, we observe the following:

- A coordinated package of tort reforms is more likely than individual reforms to achieve savings in malpractice losses and insurance premiums.
- Key among the reforms in the package are a cap on non-economic awards (on a per-event basis and at some level low enough to have an effect; such as MICRA's \$250,000) and a mandatory collateral source offset rule.
- Such reforms may not assure immediate rate reductions, particularly given the size of some increases being implemented currently, as the actual effect, including whether or not the reforms are confirmed by the courts, will not be immediately known.
- These reforms are unlikely to eliminate claim severity (or frequency) changes but they may mitigate them. The economic portion of claims is not affected if a non-economic cap is enacted. Thus rate increases still will be needed.
- These reforms should reduce insurer concerns regarding dollar awards containing large, subjective non-economic damage components and make the loss environment more predictable.
- Poorly crafted tort reforms could actually increase losses and, therefore, rates.

### FREQUENT MISCONCEPTIONS

In closing, it might be helpful to address some frequent misconceptions about the insurance industry and medical malpractice insurance coverage.

*Misconception 1: "Insurers are increasing rates because of investment losses, particularly their losses in the stock market."*

As we have pointed out, investment income plays an important role in the overall financial results of insurers, particularly for insurers of medical professional liability, because of the long delay between payment of premium and payment of losses. The vast majority of invested assets are fixed-income instruments. Generally, these are purchased in maturities that are reasonably consistent with the anticipated future payment of claims. Losses from this portion of the invested asset base have been minimal, although the rate of return available has declined.

Stocks are a much smaller portion of the portfolio for this Group, representing about 15 percent of invested assets. After favorable performance up through the latter 1990s, there has been a decline in the last few years, contributing to less favorable investment results and overall operating results. Investment returns are still positive, but the rates of return have been adversely affected by stock declines and more so by lower fixed income investment yields.

In establishing rates, insurers do not recoup investment losses. Rather, the general practice is to choose an expected prospective investment yield and calculate a discount factor based on historical payout patterns. In many cases, the insurer expects to have an underwriting loss that will be offset by investment income. Since interest yields drive this process, when interest yields decrease, rates must increase.

*Misconception 2: "Companies operated irresponsibly and caused the current problems."*

Financial results for medical liability insurers have deteriorated. Some portion of these adverse results might be attributed to inadequate knowledge about rates in newly entered markets and to being very competitive in offering premium discounts on existing business. However, decisions related to these actions were based on expectations that recent loss and investment markets would follow the same relatively stable patterns reflected in the mid-1990s. As noted earlier, these results also benefited from favorable reserve development from prior coverage years. Unfortunately, the environment changed on several fronts (loss cost levels increased, in several states significantly; the favorable reserve development ceased; investment yields declined; and reinsurance costs jumped).

While one can debate whether companies were prudent in their actions, today's rate increases reflect a reconciliation of rates and current loss levels, given available interest yields. There is no added cost for past mispricing. Thus, although there was some delay in reconciling rates and loss levels, the current problem reflects current data.

*Misconception 3: "Companies are reporting losses to justify increasing rates."*

This is a false observation. Companies are reporting losses primarily because claim experience is worse than anticipated when prices were set. Several companies have suffered serious adverse consequences given these financial results, including liquidation or near liquidation. Phico, MIIX, Frontier and, most recently, the Reciprocal of America, are all companies forced out of the business and in run-off due to underwriting losses. Further, the St. Paul Cos., formerly the largest writer of medical malpractice insurance, is now in the process of withdrawing from this market. One reason for this decision is an expressed belief that the losses are too unpredictable to continue to write the business.

The Academy appreciates the opportunity to provide an actuarial perspective on these important issues and would be glad to provide the subcommittee with any additional information that might be helpful.

**INSERT OFFSET FOLIO 8 HERE**

Mr. BILIRAKIS. Let's see. Mr. Hiestand. Is that correct?  
 Mr. HIESTAND. Hiestand.  
 Mr. BILIRAKIS. Thank you.

#### STATEMENT OF FRED J. HIESTAND

Mr. HIESTAND. There was once a Member of Congress, actually there were two by that name. But I don't know whether we are related. Anyway I appreciated hearing the opening remarks of everyone, and sort of feel from listening to that, that I am not sure how much we have to teach you. You seem to be well versed on it. But it does sound to me simply like *deja vu* all over again, as Yogi Berra would say. Because when I first had my baptism over this issue, it was back in California in 1974 through 1976 when Henry Waxman, who was then the chairman of the Assembly Health Committee, asked if I would be the consultant on medical malpractice because a number of health care providers, professional associations, had said to him at the time as the chairman of the Health Committee, that this was a burgeoning problem.

They had experienced just a couple of years previously, some very large increases in their malpractice rates, and they wanted him to look into it and see what could be done. I think Mr. Waxman asked me to get involved because we worked together, and I knew nothing about the subject, meaning I didn't have a bias one way or the other, though I suppose since my background was as a poverty and public interest lawyer up until then, I had a bias, it was sort of plaintiff-oriented. The notion that we would all had been taught in law school was the purpose of the tort system was to restore people to whole and restoring people to whole meant every kind of damage that could be brought to bear on the subject in the way of compensation.

But I did what you are all familiar with doing when I became the consultant of this committee, and that is, go around and interview all the experts on the subject, the self-identified and other recognized experts, and then we set up hearings and we held a number of hearings and produced a committee report that made recommendations that are now mirrored in H.R. 5 the heart of it I would say, the recommendations on collateral source, you know, other sources of income that injured people are entitled to receive for the injuries they are suing on, besides just the damages from the defendant, periodic payments for future injuries that people are going to get, or future damages that they would get; sliding contingency fee scale so that the more seriously injured patients got a larger share of the income than the attorney and so forth.

Now, one of the recommendations that fell on the cutting room floor and turns out to be the heart of MICRA was the limit on non-economic damages. That was felt when the preliminary report came out in June 1974 predicting that there was going to be a crisis, but, of course, we predicted what everybody told us with the exception of the organized plaintiffs bar that there was a crisis and that was going to hit some time soon. You predict those things and you never know whether you are going to be accurate or not. We, unfortunately, were more accurate than we wanted to be because in December of that year, California physicians, hospitals and oth-



ers were hit with 400 percent increases in their malpractice insurance premiums.

And Mr. Waxman left and came back to Congress. I was still sort of stuck there as consultant to the Select Committee, which Howard Berman had taken over at the time. And we had been discussing what we were going to do with that committee in his office when the calls came in from the reporters about the increase in the malpractice rate.

So the crisis hit California, but at least we had some recommendations about what to do about it that had been based on a 2-year study and a lot of hearings. And Governor Brown called a special session and asked if I would be his advisor on malpractice, and that is when he really put his finger on what I think is one of the early seminal views about why you probably need to limit non-economic damages when you have this kind of a crisis. He asked me if anything had been left on the cutting room floor, Governor Brown did in the way of recommendations, and I said yeah, the limit on non-economic damages. He asked why. I said it was felt to be maybe too draconian, too controversial, so we just left it out.

And he said, well, what is controversial about it and I said limiting people for non economic damages just didn't strike people right. And his remark to me was, have you read Roger Traynor's dissenting opinion in the case of Seffert versus L.A. Transit Authority? And to those of you not familiar with Roger Traynor, he was the chief justice for the California Supreme Court for a number of years, one of the most respected liberal jurists and the father of modern products liability law, a big believer in loss spreading. Roger Traynor's dissenting opinion in that case, which was, in 1962, over an award of about \$54,000 said, you know, you can't continue to pay people for non-economic damages if you really want to compensate them for their true losses.

But that is not for the courts to decide, he said. It is for the legislature. So Governor Brown suggested that we do limit non-economic damages, and when the democratically controlled legislature faced with that crisis, they came up with a limit of \$250,000, which seems, according to the Office of Congressional Office of Technology Assessment, the Rand Corporation and the Health and Human Services Agency, has been the single most important factor responsible for keeping malpractice premiums from skyrocketing out of hand in California.

So we like what you are doing in H.R. 5. We think things have been stable in California for more than a quarter of a century now as a result of MICRA. We wish we never had to face the crisis, but it turns out we came up with a solution that seems to work. And we hope it would work for everybody else. Thank you.

[The prepared statement of Fred J. Hiestand follows:]

PREPARED STATEMENT OF FRED J. HIESTAND, CEO AND GENERAL COUNSEL,  
CALIFORNIANS ALLIED FOR PATIENT PROTECTION

Mr. Chairman and Members of the Committee: Thank you for the invitation to share with you the background of how California learned to control what was once its own runaway medical liability insurance crisis.

From 1974-76, I was immersed in an emergency over the cost and availability of medical liability insurance for California doctors and hospitals—first as the consult-

ant to the Legislative Committee that studied its causes and predicted its occurrence, and then as advisor to the Governor and the Legislature who had to come to grips with it through the enactment of legal reforms. Now and for the past four years I have served as CEO and General Counsel to CAPP, a broad based organization of health care providers, professional medical associations, medical liability carriers and community clinics dedicated to preserving and protecting those very legal reforms that took effect in 1976 and tamed our state's medical liability crisis. This almost thirty year journey of biography as history underscores that what we learn from the past may help us to avoid repeating its unfortunate excesses. It also counsels CAPP and our allies to support federal efforts to bring uniformity and certainty to the malpractice crises now afflicting numerous states through legislation modeled on California's experience, such as HR 5. Here, in a "nutshell" is that history.

#### THE CALIFORNIA EXPERIENCE, OR DEJA VU ALL OVER AGAIN

In late 1974 California physicians and hospitals were shocked by announcements from the major insurance companies writing medical liability coverage for them that their premiums needed to be raised 400%. This calamity was predicted by the Assembly Select Committee on Medical Malpractice in a report issued earlier that summer by its chairman, Assemblyman Henry A. Waxman, which warned that:

[M]edical malpractice group insurance rates for doctors have increased more than four hundred percent (400%) in just two brief years between 1968 and 1970; [moreover,] [t]he medical malpractice insurance market is a highly unstable one and, if rates continue to escalate as they have in the past few years, malpractice insurance carriers may be priced outside the market.

(Preliminary Report, Assembly Select Committee on Medical Malpractice, June 1974, Pp. 3-4.)

Waxman's warning was prescient, though it did not anticipate the suddenness or severity of California's medical malpractice insurance crisis. Alarmed hospitals and physicians responded to it by restricting medical care to emergencies. Access to needed health care was jeopardized for Californians in the same way it is today threatened for citizens in Florida, New York, Nevada, Kentucky, Ohio, Pennsylvania, West Virginia and other states undergoing their own medical malpractice insurance crises. Within a few months newly elected Governor Jerry Brown called an extraordinary session of the Legislature in which he proclaimed:

The cost of medical malpractice insurance has risen to levels which many physicians and surgeons find intolerable. The inability of doctors to obtain such insurance at reasonable rates is endangering the health of the people of this State, and threatens the closing of many hospitals. The longer term consequences of such closings could seriously limit the health care provided to hundreds of thousands of our citizens.

(Proclamation of Governor Edmund G. Brown, Jr. to Leg. (May 16, 1975) Stats. 1975 (Second Ex. Sess. 1975-1976) p. 3947.)

Not everyone agreed at the time that there was a real crisis in California. Personal injury attorneys charged, as they do today about the catastrophes sweeping other states, that California's malpractice insurance emergency was "contrived," a result of bad stock market losses by insurers. To separate fact from fantasy California's Joint Legislative Audit Committee ordered the Auditor General to undertake a study to determine the reasons for the crisis. In December 1975 that study, contracted by the Auditor General to Booz-Allen Consulting Actuaries, reported that "premiums paid by California doctors for medical malpractice insurance have increased significantly over the past fifteen years, but have not kept pace with increasing claim costs; [and] the average premium in 1976 is expected to be about five times higher than the 1974 average." (California Medical Malpractice Insurance Study, Report by Booz, Allen & Hamilton, Inc. for the Office of the Auditor General, State of California, Dec. 5, 1975, Pp. 1-2.)

By the time the Auditor General reported that California's malpractice insurance crisis was indeed "real," the Legislature enacted the Medical Injury Compensation Reform Act of 1975 ("MICRA"). MICRA's purpose is stated in its preamble:

The Legislature finds and declares that there is a major health care crisis in the State of California attributable to skyrocketing malpractice premium costs and resulting in a potential breakdown of the health delivery system, severe hardships for the medically indigent, a denial of access for the economically marginal, and depletion of physicians such as to substantially worsen the quality of health care available to citizens of this state. The Legislature, acting within the scope of its police powers, finds the statutory remedy herein provided is intended to provide an adequate and reasonable remedy within the limits of

what the foregoing public health and safety considerations permit now and into the foreseeable future.  
(Stats. 1975, Second Ex. Sess. 1975-1976, ch. 2, § 12.5, p. 4007.)

#### THE "KEY LEGAL REFORMS" FOR TAMING RUNAWAY MALPRACTICE LITIGATION AND LIABILITY PREMIUMS

The "statutory remedy" that tamed runaway malpractice premium costs was comprehensive and dealt with major changes in the regulation of the medical profession, insurance and legal reforms. Most of these reforms were recommended by the Assembly Select Committee on Medical Malpractice that Henry Waxman chaired in 1974 and Governor Jerry Brown urged be adopted in his proclamation calling the Legislature into a special session to solve the crisis. MICRA's legal reforms curbed unfair practices and inefficiencies in our system for resolving medical malpractice disputes. It put a ceiling of \$250,000 on exploitive non-economic "pain and suffering" damages, and assured full compensation for economic losses: wages, medical bills, rehabilitation and custodial care for as long as necessary.

MICRA also permits arbitration of medical liability disputes, lets the jury know of other payments a plaintiff is receiving for the same injuries sued on, marshals and preserves resources for ongoing care of the plaintiff by allowing periodic payment of future damages, and assures that the most severely injured plaintiffs get a proper share of any recovery by requiring that attorneys' contingency fees be paid on a sliding scale—the larger the recovery the smaller the lawyer's percentage.

MICRA achieved for California stable and, in comparison to the rest of the country, reasonably affordable malpractice insurance premiums charges. States without MICRA reforms are now experiencing their own version of California's mid-1970s medical liability crisis. Since 1975, *California's premiums have risen 168 percent, while the average U.S. premium has increased 420 percent.* Today, as the chart below shows, the average annual liability premium for an Ob/gyn doctor in California is \$48,700, half the average doctors pay in the rest of the country.

#### THE IMPORTANCE OF THE \$250,000 CEILING ON NON-ECONOMIC DAMAGE

A seminal opinion upholding the validity of MICRA against constitutional attack affirmed that "the goal of [the \$250,000 limit on recoverable non-economic damage] [is] to ensure the availability of health care and the enforceability of judgments against health care providers by making medical malpractice insurance affordable. The amount of non-economic damages is still limited to \$250,000 for each injured plaintiff and thus will not result in "the unknown possibility of phenomenal awards for pain and suffering that can make litigation worth the gamble..." (*Fein v. Permanente Medical Group* (1985) 38 Cal.3d 137, 163.)

Courts have consistently and repeatedly made clear the purpose of MICRA and its non-economic damage provision:

The legislative history of MICRA does not suggest that the Legislature intended to hold down the overall costs of medical care but instead demonstrates... that the Legislature *hoped to reduce the cost of medical malpractice insurance, so that doctors would obtain insurance for all medical procedures and would resume full practice; indeed, in this respect [available] statistics suggest that MICRA was in fact successful.* The statistical information before the Legislature

indicated, however, that insurance costs amounted to only a small percentage of overall medical costs (see, e.g., Assem. Select Com. on Medical Malpractice Preliminary Rep. (June 1974) p. 49), and thus in an era of substantial inflation—as experienced in the late 1970’s—even the total elimination of malpractice insurance premiums could not reasonably have been expected to reduce the overall cost of medical care.

(*American Bank & Trust Co. v. Community Hosp. of Los Gatos* (1985) 36 Cal. 3d 359, 373; italics added.)

Restricting recovery for non-economic loss is neither a novel nor radical notion. Former Chief Justice Roger Traynor, the father of modern products liability law and advocate for “spreading the loss” of injury compensation through insurance, long ago recognized the need to cabin these subjective and highly elastic damages. In *Seffert v. L.A. Transit Authority* (1961) 56 Cal.2d 498, Traynor dissented from approval of a non-economic damage award of \$134,000 in a negligence action to a woman whose foot was injured while boarding a city bus and whose economic losses were about \$54,000.

There has been forceful criticism of the rationale for awarding damages for pain and suffering in negligence cases. Such damages originated under primitive law as a means of punishing wrongdoers and assuaging the feelings of those who had been wronged. They become increasingly anomalous as emphasis shifts in a mechanized society from ad hoc punishment to orderly distribution of losses through insurance and the price of goods or of transportation.... [¶] [A]ny change in this regard must await reexamination of the problem by the Legislature.

When the Legislature followed Justice Traynor’s suggestion and reexamined the problem of non-economic damage awards in the context of the malpractice insurance crisis of 1975, it decided to cap them at \$250,000. The considered judgment of the Legislature and the Governor was that limiting recovery for non-economic damages to that amount would dampen the skyrocketing cost of medical malpractice insurance. This policy decision has withstood numerous legal challenges because it is right.

The continuing availability of adequate medical care depends directly on the availability of adequate insurance coverage, which in turn operates as a function of costs associated with medical malpractice litigation. Accordingly, MICRA includes a variety of provisions, all of which are calculated to reduce the cost of insurance by limiting the amount and timing of recovery in cases of professional negligence. [¶] MICRA thus reflects a strong public policy to contain the costs of malpractice insurance by controlling or redistributing liability for damages, thereby maximizing the availability of medical services to meet the state’s health care needs. With specific reference to [the ceiling on non-economic damage], this court has also observed that “[o]ne of the problems identified in the legislative hearings was the unpredictability of the size of large non-economic damage awards, resulting from the inherent difficulties in valuing such damages and the great disparity in the price tag...different juries place on such losses. The Legislature...reasonably...determined that an across-the-board limit would provide a more stable base on which to calculate insurance rates.”

(*Western Steamship Lines, Inc. v. San Pedro Peninsula Hospital* (1994) 8 Cal.4th 100, 112, citing and quoting from *Fein v. Permanente Medical Group*, *supra*, 38 Cal.3d at 163.)

MICRA’s non-economic damage cap and those from nineteen other states echoing it have arrested spiraling malpractice insurance premium charges. As one scholarly study<sup>1</sup> states:

The weight of empirical evidence suggests that...some of the legal reforms had the intended effect of stabilizing liability insurance markets and reducing the overall level of medical malpractice payments. The largest reductions in payments and premiums were attributable to a few provisions, notably caps on awards and modifications of the collateral source rule...

Other studies about the benefits of the damage cap on malpractice insurance rates reached the same conclusion. A 1995 study by the American Academy of Actuaries found, for example, that in California (since MICRA was enacted) medical mal-

<sup>1</sup> Bovbjerg & Sloan, *No-Fault for Medical Injury: Theory and Evidence* (1998) 67 U. Cin. L. Rev. 53, 62 (italics added). For empirical evidence on the impact of tort reforms, see Danzon, *The Frequency and Severity of Medical Malpractice Claims* (1984) 27 J.L. & Econ. 115; Hamilton, Rabinowitz, & Alschuler, Inc., Claim Evaluation Project (1987); Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence* (1986) 49 Law & Contemp. Probs. 57; Sloan et al., *Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis* (1989) 14 J. Health Pol. Pol’y & L. 663.

practice costs have fallen substantially from about 28 percent of the national total in 1975 to about 10 percent in 1994—while California's share of physicians held steady at 15 percent.<sup>2</sup> Paralleling this decrease, the state's portion of national malpractice premium costs was sliced in half. In New York, however, where a damage cap was never enacted despite the adoption of other piecemeal reform measures over the years, there were no observable improvements in the state's relative costs. New York's physician population hovered between 12 and 14 percent of the national total, but its malpractice losses zigzagged from just above 16 percent of the national cost in 1975 to 22 percent in 1979, to about 15 percent in 1985, and back to above 22 percent in 1993.<sup>3</sup> Ohio experienced a gradual decline—about one percent from 4 to 3 percent—in costs following tort reforms enacted in 1975.<sup>4</sup> This package included a cap on damages that was challenged in court in 1982, resulting in sharp increases that peaked in 1985 (at 6 percent) when the cap was overturned. Ohio's loss payments remained fairly constant until this year, when premium charges spiraled over the top for doctors in high risk specialties.<sup>5</sup>

In 1995, the congressional Office of Technology Assessment also confirmed that "caps on damage awards were the *only* type of State tort reform that consistently showed significant results in reducing the malpractice cost indicators."<sup>6</sup> This same conclusion was recently reached by the federal Department of Health and Human Services (HHS), which reported that "a major contributing factor to the most enormous increases in liability premiums has been the rapidly growing awards for non-economic damages in states that have not reformed their litigation system to put reasonable standards on these awards."<sup>7</sup> The HHS report emphasizes that the medical malpractice insurance crises now engulfing twelve states "is less acute in states that have reformed their litigation systems. States with limits of \$250,000 or \$350,000 on non-economic damages have average combined highest premium increases of 12-15%, compared to 44% in states without caps on non-economic damages."<sup>8</sup>

The HHS study credits MICRA, especially its ceiling on recoverable non-economic loss, for holding down medical malpractice insurance rate increases and keeping open access to health care:

California has more than 25 years of experience with this reform. It has been a success. Doctors are not leaving California. Insurance premiums have risen much more slowly than in the rest of the country without any effect on the quality of care received by residents of California. Insurance premiums in California have risen by 167% over this period while those in the rest of the country have increased 505%. This has saved California residents billions of dollars in health care costs and saved federal taxpayers billions of dollars in the Medicare and Medicaid programs.<sup>9</sup>

MICRA's substantial public benefits through reduced malpractice premium costs have not come at the expense of plaintiffs' ability to be fairly compensated for their losses. "Leading malpractice carriers report that between 1984 and 1997 payments to [medical] malpractice plaintiffs...increased 139 percent while inflation grew less than half that amount (54.5%) and health care costs rose less than 120 percent."<sup>10</sup>

A plaintiff in a \$400,000 medical malpractice case in 1984, where half the award was for non-economic damage, today would receive \$1.195 million, or \$442,500 more than what the injury is worth measured by the rise in the cost of living. This result is likely due to plaintiffs' attorneys creatively exploiting

<sup>2</sup> *Actuaries Use States' Experiences To Argue For Comprehensive Malpractice Reforms*, 22 Health Legislation & Regulation 47 (Nov. 27, 1996)(Faulkner & Gray, Inc.).

<sup>3</sup> *Id.*

<sup>4</sup> *Id.*

<sup>5</sup> "A study released this week by *Medical Liability Monitor*...found that four insurers are charging Cleveland-area obstetricians from \$74,581 to \$152,496 this year for malpractice coverage.... A bill pending with the Ohio legislature would place a \$300,000 cap on non-economic awards for pain and suffering in medical malpractice.... Nineteen states already have limits, ranging from \$200,000 to \$1 million.... [T]he average premium for obstetricians nationwide was \$56,546. In states with tort reform, that figure ranges from \$17,786 to \$55,084." (Powell, *Docs Preach at Practices—Physicians Say Limiting Malpractice Awards will Lower Insurance Costs*, Akron Beacon Journal, Oct. 10, 2002, p. 1.)

<sup>6</sup> U.S. Congress, Office of Technology Assessment, *Impact of Legal Reforms on Medical Malpractice Costs*, OTA-BP-H-119, p. 64 (Washington, D.C.: U.S. Gov't. Printing Office, Oct. 1995).

<sup>7</sup> *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing our Medical Liability System* 12 (Health and Human Services: July 24, 2002).

<sup>8</sup> *Id.* at p. 14.

<sup>9</sup> *Id.* at p. 17.

<sup>10</sup> Hiestand, *MICRA Management*, Los Angeles Daily J., March 4, 1999, p. 6.

what they get (unlimited economic loss) to offset the MICRA limit [on non-economic loss].<sup>11</sup>

Numerous scholarly studies show that the \$250,000 ceiling on non-economic damages is a major factor accounting for the principal difference between California's stability and the chaos of other states in professional liability coverage costs. Despite these savings, the average malpractice settlement and award in California, adjusted for post-MICRA inflation, is greater today than it was before MICRA. Without MICRA, pay outs by California carriers on behalf of health care providers sued for professional liability would mirror the claims experience of other states and send corresponding coverage costs through the roof.

California's medical malpractice disputes are settled 23 percent faster than in the rest of the country. The cost of settlements is 53 percent lower than the national average. The Congressional Budget Office stated that medical malpractice reform like California's will result in savings of \$1.5 billion over ten years. The congressional study does not include the hidden costs of defensive medicine. A Stanford University study shows that California's medical liability reforms would save the national health care system \$50 billion a year in defensive medicine costs. Reducing health care costs safeguards access to medical care for those who lack basic health coverage.

MICRA is a proven success. Medical liability no longer deprives our citizens of access to health care. Congress and other states now look to the California experience as they try to fashion solutions to the growing emergency with medical liability insurance. MICRA continues to prove that providing fair and equitable compensation for those negligently injured can be achieved in ways that preserve an orderly insurance marketplace and maintain access to quality health care. It is a success for Californians, and if enacted by Congress will benefit patients and taxpayers nationally.

Mr. BILIRAKIS. Thank you very much Mr. Hiestand.  
Mr. Rosenfield.

#### STATEMENT OF HARVEY ROSENFELD

Mr. ROSENFELD. Thank you, Mr. Chairman. Good morning, members of the committee. My name is Harvey Rosenfield. I am the president of the, Foundation for Taxpayer and Consumer Rights, which is a Los Angeles-based consumer and citizen advocacy organization. Mr. Chairman, what brought us to the table at this hearing today, would be an effort to stop the epidemic of medical malpractice, which claimed the lives of between 100- and 150,000 Americans every year in hospitals alone.

Instead, we are worrying about how much doctors have to pay for medical malpractice coverage, though for most of them, it is between 1 and 5 percent of their annual revenues, and it is tax deductible. And all the premiums for medical malpractice and all the payments by insurance companies for claims amount to an infinitesimal fraction of our national health care expenditures.

Nevertheless, because of the doctors on strike and some doctors experiencing tremendous rate increases, we are here today to talk about whether MICRA will lower insurance premium. And on that, California can give some guidance because there is a law in California that lowered insurance premiums for doctors and that refunded \$135 million in premiums to physicians. I was the author of that law. It was not MICRA. It was proposition 103.

If I could have Exhibit 1, please, on the presentation. If you look at the chart that is contained in the second page of our testimony, you will see the following: In 1975 the legislature passed MICRA in the midst of a crisis, panicked, doctors striking, special session of the legislature. Rates after MICRA passed, between then and 1988 with a brief dip after the insurance crisis of the 1970's ended

<sup>11</sup> *Id.*

and the insurance industries performance in the economy improved, premiums for physicians rose between 1975, and 1988, under MICRA, 450 percent.

Physicians point out that MICRA, the cap in MICRA was not upheld until February 1985. Between 1985 and 1988, which was the second insurance crisis in the last three decades when the insurance companies ran into trouble with their investments and interest rates dropped, between those years, after the MICRA cap was upheld as constitutional, premiums went up 47 percent alone in those 3 years. During the 13 years of MICRA, insurance companies, medical malpractice insurers operating in California, paid out only 31 cents in claims for every dollar they took in.

In 1988, the voters got fed up with the absence of lower insurance premiums, despite repeated so-called tort reform in California, and so they put proposition 103 on the ballot. Proposition 103 mandated a rate freeze, a 20 percent rollback, stringent regulation of the profits expenses, and most importantly for our debate today, projections of future losses. It repealed the industry's antitrust exemption, created an elected insurance commissioner, and gave the public the right to challenge unjustified rate changes.

Insurance companies spent \$80 million to try to defeat prop 103 at the ballot box, which gives you some idea of the amount of fear that is reflected in the fact that to this day, and before this committee, you are going to be told that it didn't work, even though the results are in disputable. Proposition 103's \$1.2 billion in rate refund checks included \$135 million from medical malpractice insurers to physicians.

And don't you believe that when they tell you today that oh, these insurance companies were going to roll back their rates anyhow, because they fought prop 103 bitterly in the courts. They spent tens of millions of dollars on attorneys' fees to try to stop that initiative, and only when they lost everything did they finally understand as an industry that they had to role back \$1.2 billion in premiums. After proposition 103 passed in the 13 years that we have data for, premiums went down 20 percent in the first 3 years, and then between then, 1988 and 2001, premiums in California for medical malpractice went down an average of 2 percent.

Tort reform has never lowered insurance premiums anywhere in the country at any time, any kind of tort reform. The insurance industry itself has admitted that in Florida and other States. Why does 103 work? 103 works because the crisis concerns the investment and interest rate and investment income of the insurance companies and the fear of regulation and the actual regulation of prop 103 lowered insurance premiums. Mr. Chairman, I have 1 minute to talk about MICRA if I may, please. If you will indulge that.

Mr. BILIRAKIS. Go ahead, sir.

Mr. ROSENFELD. Here is what MICRA has done in California. For those of you who really want to understand what it has done, it has prevented innocent victims of medical malpractice from getting lawyers because the combination of the caps on the damages, the sliding scale caps on the attorney's fees, and the requirement that taxpayer programs pay for the victims before the doctor or the negligent hospital or the insurance company pay, has made it fi-

nancially economically impossible for attorneys to take all but the most serious cases involving all but the most wealthy people. Health care, which HMO based financial driven health care, in which bean counters make decisions about how the quality of medicine is delivered, combined with the MICRA caps, have been a disaster for this State.

I want to conclude with this, Mr. Chairman. For 200 years, American juries have been deciding how to allocate personal responsibility in our country. I want to say that the principle that should guide this committee as the Congresswoman suggested at the beginning, should be the principle that ought to be followed by the American Medical Association and the minority of American doctors who are following the AMA in this campaign against the rights of patients. First do no harm. With all due respect to members of this committee, I ask you, why you should substitute your judgment for juries. I ask you to search your hearts and explain to us, tell us who are you to tell Heather Lewinski how much her pain and suffering is worth? Thank you very much, Mr. Chairman.

[The prepared statement of Harvey Rosenfield follows:]



**INSERT OFFSET FOLIOS 9 TO 42 HERE**

Mr. BILIRAKIS. Thank you very much, sir.  
Ms. Rosenbaum.

#### STATEMENT OF SARA ROSENBAUM

Ms. ROSENBAUM. Good morning Mr. Chairman, members of the subcommittee. I am a law professor at the George Washington University Medical Center, and I am particularly cognizant of the problems that malpractice insurance premium cost increases are causing for my colleagues. And I have great hope that this committee and Congress ultimately can find a legislative approach to this problem that will give them some relief. My background as a law professor has me regularly read statutes and my conclusion about the legislation that is before you today is that this bill, read in its most common sense fashion, goes far, far beyond the problem that, it is my understanding, you are here to address.

There are two problems or two issues that this bill really deals with, and it has two pieces of operating legislative proposals in them. One is provisions designed to regulate the procedures that are used in the health care lawsuit, as the bill defines them. The other is a preemption of certain kinds of claims against health care providers and manufacturers in health care lawsuits. It is the preemption part of this bill that I want to focus on.

In the legislation, the term health care lawsuit is defined as any health care liability claim concerning the provision of health care, goods and services, regardless of the theory of liability on which the claim is based. A liability claim is a demand by any person, whether or not against a health care provider, which is based on the provision of use of or payment for health care services.

Because of the choices made in drafting this bill, the concept of who are plaintiffs, who are defendants and what is a claim covered by the preemption provisions of the bill are enormous. Plaintiffs, because the word any is used in describing any person, could be State attorneys general, could be an assistant United States attorney, it could be government officials acting under the color of law, pursuing civil or criminal charges that result in monetary award or monetary damages, civil money penalties, anything that results in the payment of money.

It is really not clear where the limits end on who is a plaintiff. And in addition, the—because the bill reaches both actions and claims, the use of the word “action” is quite distinct from the use of the word “claim.” an action is a common term of art in drafting used to describe enforcement actions as well as individual civil actions. Defendants, of course, are limitless in this bill because of the use of the term “manufacturer,” provider of health care goods and services. The kinds of claims that would fall within the ambit of this bill, even though the procedural provisions might not apply, but the claims that would be preempted go far, far beyond common law or statutory claims arising under State law that involve professional negligent on the part of physicians.

Claims that sound in fraud, claims that sound in unfair practices, violations of civil rights laws, violations of labor laws, potentially violations of criminal laws, violations of consumer protection statutes, violation of antitrust laws, violations of environmental laws. All of these claims, potentially, are swept into the preemption

provisions of the statute. And the preemption provisions reach Federal laws as well, because the bill is quite clear in which laws are saved. But interestingly, it saves defenses, but it doesn't save claims. So Federal fraud claims, Federal antitrust claims, Federal civil rights claims, criminal claims, environmental law claims, labor claims. I could not find the end point of the claims in this bill.

My testimony provides you with examples actually drawn mostly from either cases that have been litigated in court or that are pending at this point involving the kinds of claims resulting in large financial recoveries that might or might not be a preempted claim under this bill. The examples range from hundreds of millions of dollars in restitution as a result of RICO violations by large health care corporations to toxic waste dumping, by manufacturers of medical care goods and devices, to, obviously, billions of dollars in claims brought by people injured when they use a pharmaceutical drug or device as directed.

All of this seems to fall within the ambit of this bill, and I think that, in that sense, the bill goes well beyond what you need to do in order to provide reliever to physicians. Thank you.

[The prepared statement of Sara Rosenbaum follows:]

PREPARED STATEMENT OF SARA ROSENBAUM, HAROLD AND JANE HIRSH PROFESSOR, HEALTH LAW AND POLICY, INTERIM CHAIR, DEPARTMENT OF HEALTH POLICY, THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER, SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES

Mr. Chairman and Distinguished Members of this Subcommittee: I am a professor of health law and policy at the George Washington University, specializing in health services law. I am the co-author of one of the nation's leading health law textbooks and have regularly appeared as a Congressional witness over the past 25 years.

Thank you for inviting me to present testimony on H.R. 5, The Help Efficient, Accessible, Low Cost, Timely Healthcare (HEALTH) Act of 2003. My testimony will focus on the scope of the legislation's proposed shield against non-economic damages with respect to the plaintiffs whose claims would be affected, the corporate defendants that would benefit from the shield, and the types of injuries that would be shielded.

H.R. 5 is drafted broadly and is ambiguous in its use of terms and definitions. However, reading the bill in a common sense fashion, I have concluded that this measure is so vast in scope that it reaches every conceivable health care claim against every health care corporation or manufacturer of health care products, regardless of whether the violation of law in question bears any relationship to what would reasonably be considered the types of injury commonly associated with the concept of medical liability. In this sense the measure extends far beyond its popular billing as one related to the crisis facing physicians and other medical professionals in individual practice.

#### KEY ELEMENTS OF H.R. 5

H.R. 5 would establish federal standards for causes of action that fall within a new federal definition of "health care lawsuit." The term "health care lawsuit" is defined as

"any health care liability claim concerning the provision of health care goods or services affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, or market, promoter or seller of a medical product, regardless of the theory of liability on which the claim is based \* \* \* " § 9(7)

A health care liability claim means

A demand by any person, whether or not pursuant to ADR against a health care provider, health care organization, or the manufacturer, distributor, supplier, marketer or promoter or seller of a medical product \* \* \* which are based on the provision of, use of, payment for (or the failure to provide, use or pay for)

health care services or medical products, regardless of the theory of liability on which the claim is based \* \* \* § 9(9)

The term "health care goods or services" means

Any goods or services provided by a health care organization, provider or by any individual working under the supervision of a health care provider that relates to the diagnosis, prevention or treatment of any human disease or impairment or the assessment of the health of human beings." § 9(12)

The term "medical product" encompasses both drugs and devices as defined under the federal Food, Drug and Cosmetic Act. § 9(14). Because it would be the Sense of Congress that a "health insurer should be liable for harm caused when it makes a decision as to what care is medically necessary and appropriate," § 13, I interpret this provision to extend a shield to managed care organizations for both acts of medical negligence and negligent medical decision-making in the context of coverage determinations.

#### THE SCOPE OF THE SHIELD AGAINST DAMAGES IN H.R. 5

The popular understanding of this legislation, as reflected in press coverage, is that it is intended to shield individual clinical practitioners against punishing liability judgments. However, the bill's actual reach is breathtaking.

##### *Plaintiffs*

Because the definitions reach actions by "any" person, I interpret this to cover individual, private legal claimants as well as State Attorneys General and the U.S. Attorney General representing the public interest under public laws that permit financial recoveries of any kind (money damages, civil money penalties, fines, and other financial penalties).

I have reached this conclusion based on the fact that the bill specifically reaches both "action" and "claim," and that a customary use of the term "action" is to describe governmental enforcement actions that may carry criminal, injunctive or monetary penalties. The bill appears to contain no provision that exempts enforcement actions brought by federal or state public officials.

##### *Defendants*

The sweep of the above-cited definitions mean that any corporate defendant engaged in the "health care" business would be covered by the shield, regardless of the size of the corporation or the nature of the offense. The only exception to the shield would be if an individual plaintiff could prove either a deliberate failure on the defendant's part to avoid unnecessary injury or a malicious intent to injure, which is defined as "intentionally causing or attempting to cause physical injury other than providing health care goods or services." § 9(13).

##### *Claims*

The measure appears to encompass within the scope of the claims to which the shield applies every conceivable health care liability claim under law, not simply claims involving professional medical negligence of a clinical nature. Thus, criminal laws, laws to prevent anticompetitive conduct, civil rights law, worker protection law, and environmental laws all appear to fall within the ambit of the protection. Every conceivable claim appears to be affected regardless of underlying theory (defenses would be preserved). Examples of State law claims theories are:

- common law or statutory medical negligence claims (either individual or against medical care corporations under vicarious or direct theories)
- common law and statutory law theories of product liability such as breach of express or implied warranty, failure to warn, general corporate negligence, defective design, defective manufacturing
- fraud and deceit
- unfair trade practices
- civil rights laws
- labor law (including worker protection statutes)
- criminal law
- consumer protection
- antitrust law
- environmental laws

Examples of Federal law claims apparently covered by the Act are:

- fraud and abuse (e.g., RICO, False Claims Act)
- antitrust (Sherman Act, Clayton Act, other laws)
- civil rights laws
- criminal statutes

- federal food and drug laws including standards for the production and sale of prescription and over-the-counter drugs and devices and dietary supplements
- federal environmental health laws
- federal labor laws
- federal contract enforcement laws that provide for liquidated damages
- restitution to the extent that restitution is not understood to be part of economic damages

The only federal law that appears to be saved is the federal Vaccine Injury program. Otherwise, only federal defenses are preserved. H.R. 5, § 10.

#### EXAMPLES OF CLAIMS AFFECTED BY THE LEGISLATION

The following examples are meant to be illustrative of the types of claims that are filed (or could be filed) against providers of health care goods and services or manufacturers, suppliers, or promoters of medical products:

- A nationwide, publicly traded managed care corporation, with full access to the medical records of an exceedingly high risk pregnant woman, denies round-the-clock inpatient preterm management care and orders part day home care instead. An hour after the nurse leaves for the day, the woman goes into preterm labor and loses her baby before they can be transported to the hospital. The corporation rebuffed both the overwhelming evidence in her case (including a similar previous labor) as well as all appeals by her physician.
- A renowned organ transplant medical center fails to institute the most basic “redundancy” safeguards within its organ transplant surgery program, such as deliberate and repetitive matching of donor and recipient blood types. As a result, the wrong organs are transplanted and the patient dies.
- A national health care corporation is sued by the United States Attorney for knowingly and deliberately overcharging ERISA subscribers hundreds of millions of dollars in premiums by deliberately concealing the actual cost of goods and services covered, even while promising to pay 80% of subscribers’ claims. In some cases, subscribers actually paid nearly 80% of the claim as a result of fraud. The federal government seeks billions of dollars in restitution.
- A restraint of trade action is brought by generic drug manufacturers against large pharmaceutical companies for price-fixing, with the potential for recovery of treble damages under U.S. antitrust law.
- A False Claims Act case is instituted against a large for profit hospital chain for deliberately overcharging the federal government by manufacturing unnecessary surgeries through its cardiac care centers.
- A national nursing home chain is accused by HHS and the U.S. Attorney of deliberately incentivizing its members to engage in a series of unsafe practices, ranging from over-medication to the unlawful use of restraints. The same chain is accused by the Department of Labor of numerous violations of federal occupational safety violations.
- A manufacturer of medical devices develops a form of contraceptive that when used as directed causes death and injury including rare and oftentimes fatal septic abortions.
- A pharmaceutical company manufactures a drug which, when used as directed, causes a rare form of malignant vaginal cancer.
- A device manufacturer develops a heart valve that when inserted as directed, actually results in valve failures caused by fractures at the point at which struts were welded to the valve rings.
- A large manufacturer of health care goods and services fails to exercise reasonable care when getting rid of toxic manufacturing materials and succeeds in poisoning the water supply of a community.
- A pharmaceutical manufacturer produces an appetite suppressant that when taken as directed causes heart valve abnormalities, disability and death.

Virtually none of these claims relates to specific acts of professional negligence by individual clinicians while furnishing health care to patients. They all involve acts by in many cases enormous corporations, and range from violations of health laws to violations of every conceivable form of state or federal law that relates to health care services or the manufacturing of health care products.

I am happy to answer questions.

Mr. BILIRAKIS. Thank you, Ms. Rosenbaum.  
Mr. Smarr.

**STATEMENT OF LAWRENCE E. SMARR**

Mr. SMARR. Chairman Bilirakis, Congressman Brown and committee members, I am Larry Smarr, and I am the president of the Physician Insurers Association of America. The PIAA is an association comprised of professional liability insurance companies that are owned and/or operated by doctors, dentists hospitals and other health care providers. Our 43 member companies really can be characterized as health care professionals caring for the professional liability risk of their colleagues, doctors insuring doctors, hospitals insuring hospitals. We believe that our member companies insure over 60 percent of the private practicing physicians in the United States.

Over the past 3 years, medical liability insurers have seen their financial performance deteriorate substantially due to the rapidly rising costs of medical liability claims. The primary driver of the deterioration has been paid claims severity or the average cost of a paid claim. This has been confirmed by the president of the National Association of Insurance Commissioners in its February 7 letter to Senator Gregg, which is attached to my written testimony.

Exhibit A before you shows the average dollar amounts paid in indemnity to plaintiffs on behalf of the individual physicians since 1988. The mean payment amount has risen by a compound annual growth of 6.9 percent over the past 10 years, as compared to 2.6 percent for the consumer price index. The data for this exhibit comes from the PIAA data-sharing project, which is a medical cause of loss data base created in 1985 for the purpose of identifying common trends among malpractice claims, which are used for patient safety purposes by the PIAA member companies.

Right now there are over 180,000 claims and suits in this data base. One very troubling aspect is the proportion of those claims and suits filed, which are ultimately determined to be without merit. As shown on Exhibit B, 61 percent of all claims closed in 2001 were dropped or dismissed by the Court. An additional 5.7 percent were won by the doctor at trial. Only 33.2 percent of all claims closed were found to be meritorious, with most of these being made through settlement.

When claims are concluded at verdict, the defendant prevailed an astonishing 80 percent the time. As shown in Exhibit C, the mean settlement amount on behalf of an individual defendant was just over \$299,000. Most medical malpractice cases have multiple defendants, and thus these values are below those which may be reported on a case basis. The mean verdict amount last year was almost \$497,000.

Exhibit D shows the mean expense payment for claims by category or disposition, as can be seen the cost of taking a claim for each doctor named in a case, all the way through trial, is fast approaching \$100,000. And we win 80 percent of these. Exhibit E shows the distribution of claim payments at various payment thresholds. It can be readily seen that the number of larger payments represented by the upper bars on this chart are growing as a percentage of the total number of payments. This is especially true for payments at or exceeding \$1 million, which comprised almost 8 percent of all claims paid on behalf of the individual practitioners in 2001 as shown in exhibit F.

This percentage has doubled in the past 4 years. Insurers rely on investment income to offset premium needs. Medical malpractice insurers are primarily invested in high grade bonds and have not lost large sums in the stock market. Brown Brothers Harriman, a leading investment and asset management firm in a recent investment research report states that over the last 5 years, the amount medical malpractice companies have invested in equities has remained fairly constant.

In 2001, the equity allocation was 9.03 percent. As Exhibit G shows, medical liability insurance companies invested significantly less in equities than did all property casualty insurers with medical being the short black bar on that exhibit. While insurer interest income has declined due to falling market interest rates, when interest rates declined, bond values increase. This has had a beneficial effect in keeping total investment income level when measured as a percentage of total invested assets. This is shown on Exhibit H. Thus the assertion that insurers have been forced to raise their rates because of bad investments is simply not true. The answer to the current problem, the PIAA firmly believes is the adoption of effective Federal health care liability reform similar to the California MICRA reforms enacted in 1975.

The keystone of the MICRA reforms is the \$250,000 cap on non-economic damages. These reforms are similar to the provisions of H.R. 5 passed by—which is before you now. Last year's bill, H.R. 4600, was scored by the CBO as providing over \$14 billion in savings to the Federal Government, and an additional \$7 billion to the States. Using annual data published by the National Association of Insurance Commissioners, Exhibit I documents the savings California practitioners and health care consumers have enjoyed since the enactment of MICRA over 25 years ago.

As shown, total malpractice premiums reported to the NRC since 1976 have grown in California by 167 percent, compared to 505 percent in the rest of the Nation. These savings are clearly demonstrated in the rates charged to California doctors as shown on Exhibit J. Successful experience in California and other States, such as Wisconsin, make it clear that MICRA style tort reforms do work without lowering health care quality or limiting access to care. Now we have heard about prop 103. Prop 103 actually had no effect on California medical liability or premiums.

In an effort to derail desperately needed tort reforms, the Association of Trial Lawyers of America and related individuals and groups have stated that the beneficial effects shown on Exhibits I and J are due to prop 103. This is just not true. Medical liability insurers were not the intended target of prop 103, but were nonetheless subject to it. However, given the high level of dividends being paid by medical malpractice insurers at the time, they were not required by the insurance commissioner to roll back rates. While malpractice insurers did make one-time refunds equal to 20 percent of 1 year's premium, which, in these amounts, were improved in normal dividends they were paying during that period of time.

Prop 103 did not result in the lowering of insurance rates and did not result in the return of additional moneys that would have ordinarily been paid through the normal insurance dividend proc-

ess. The PIAA strongly urges members of the committee to support and pass legislation, which will assure full payment of a truly injured payment's economic losses as well as up to \$250,000 in non-economic damages, thereby assuring fair compensation for patients, and also assuring Americans that they will be able to receive necessary health care services. Thank you.

[The prepared statement of Lawrence Smarr follows:]

PREPARED STATEMENT OF LAWRENCE E. SMARR, PRESIDENT, PHYSICIAN INSURERS ASSOCIATION OF AMERICA

#### INTRODUCTION

Chairman Bilirakis, Congressman Brown and Committee Members, I am Lawrence E. Smarr, President of the Physician Insurers Association of America (PIAA). Thank you for allowing me the opportunity to appear before you today and speak about the need for the enactment of H.R.5, The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003.

As we all know, professional liability insurance premiums for doctors and hospitals are rapidly rising in many states to levels where they cannot afford to pay them. These increased premiums are caused by the ever-increasing size of medical liability insurance payments and awards. The unavoidable consequence is that physicians are moving away from crisis states, reducing the scope of their practices, or leaving the practice of medicine altogether. Likewise, hospitals are being forced to close facilities and curtail high-risk services because they can no longer afford to insure them.

#### DOCTORS INSURING DOCTORS

The PIAA is an association comprised of professional liability insurance companies owned and/or operated by physicians, dentists, and other health care providers. Collectively, our 43 domestic insurance company members insure over 300,000 doctors and 1,200 hospitals in the United States and our nine international members insure over 400,000 health care providers in other countries around the world. The PIAA member insurance companies can also be characterized as health care professionals caring for the professional liability risks of their colleagues—doctors insuring doctors, hospitals insuring hospitals. We believe that the physician owned/operated company members of the PIAA insure over 60% of America's doctors. Unlike the multi-line commercial carriers, medical liability insurance is all that the PIAA companies principally do, and they are here in the market to stay.

The PIAA was formed 26 years ago at a time when commercial insurance carriers were experiencing unanticipated losses and exited the market, leaving doctors, hospitals and other health care professionals no choice other than to form their own insurance companies. A quarter century has passed, and I am proud to say that the insurers who comprise the PIAA have become the driving force in the market, providing stability and availability for those they insure.

When the PIAA and many of its member companies were formed in the 1970's, we faced a professional liability market not unlike that which we are experiencing today. At that time, insurers, all of which were general commercial carriers, were experiencing rapidly increasing losses, which caused them to consider their continuance in the market. Many of the major carriers did indeed exit the market, leaving a void that was filled by state and county medical and hospital associations across the country forming their own carriers. Again we see the commercial carriers, such as St. Paul, exiting the market. But, this time, the provider owned carriers are in place and are indeed providing access to insurance and stability to the market.

Unfortunately, the recent exodus from and transformation of the market is of such magnitude that the carriers remaining do not have the underwriting capacity to take all comers. Facing ever-escalating losses of their own, many of the carriers remaining in the market are forced to tighten their underwriting standards and revise their business plans with regard to their nature and scope of operations. This includes the withdrawal from recently expanded markets, which adds to the access to insurance problem caused by carriers exiting altogether.

My goal here today is to discuss what the PIAA sees as the underlying causes of the current medical liability crisis. I want to stress that I believe that this situation should be characterized as a medical liability crisis, and not a medical liability insurance crisis. The PIAA companies covering the majority of the market are in sound financial condition. The crisis we face today is a crisis of affordability and



availability of insurance for health care providers, and more importantly, the resulting growing crisis of access to the health care system for patients across the country.

#### INSURANCE INDUSTRY UNDERWRITING PERFORMANCE

Medical liability insurance is called a long-tail line of insurance. That is because it takes on average two years from the time a medical liability incident occurs until a resulting claim is reported to the insurer, and another two and one-half years until the average claim is closed. This provides great uncertainty in the rate making process, as insurers are forced to estimate the cost of claims which may ultimately be paid as much as 10 years after the insurance policy is issued. By comparison, claims in short-tail lines of insurance, such as auto insurance, are paid days or weeks after an incident.

Over the past three years medical liability insurers have seen their financial performance deteriorate substantially due to the rapidly rising cost of medical liability claims. According to A.M. Best (Best), the leading insurance industry rating agency, the medical liability insurance industry incurred \$1.53 in losses and expenses for every dollar of premium they collected in 2001. While data for 2002 will not be available until the middle of this year, Best has forecast that the industry will incur \$1.41 in losses and expenses in 2002, and \$1.34 in 2003. The impact of insurer rate increases accounts for the improvement in this statistic. However, Best also calculates that the industry can only incur \$1.14½ in losses and expenses in order to operate on a break-even basis. This implies that future rate increases can be expected as the carriers move toward profitable operations.

The physician owned/operated carriers that I represent insure a substantial portion of the market (over 60%). Each year, an independent actuarial firm (Tillinghast Towers-Perrin) provides the PIAA with a detailed analysis of annual statement data filed by our members with the National Association of Insurance Commissioners (NAIC). This analysis is very revealing with regard to the individual components of insurers financial performance.

Exhibit 1 below details the operating experience of 32 physician owned/operated insurance companies included in the analysis. A widely relied upon insurance performance parameter is the combined ratio, which is computed by dividing insurers' incurred losses and expenses by the premiums they earn to offset these costs. For these companies, this statistic has been deteriorating (getting larger) since 1997, with major increases being experienced in 2000 and 2001.

For calendar year 2001, the combined ratio (including dividends paid) was 141, meaning that total losses and dividends paid were 41% more than the premiums collected. Even when considering investment income, net income for the year was a negative ten percent. This follows a meager 4 percent net income in 2000. This average experience is indicative of the problems being experienced by insurers in general, and demonstrates the carriers' needs to raise rates to counter increasing losses. All of the basic components of the combined ratio calculation (loss and loss adjustment expense, underwriting expense) have risen as a percentage of premium for all years shown. The only declining component has been dividends paid to policyholders.

To compare this group of PIAA companies with the industry, Exhibit 2 is taken from the 2002 edition of Best's Aggregates and Averages. This shows that medical malpractice is the least profitable property and casualty line of insurance in 2001, following reinsurance, which has been greatly impacted by the World Trade Center losses. The adjusted combined ratio for the entire industry is 153, as compared to 141 for the PIAA carriers represented on Exhibit 1.

#### THE ROLE OF INVESTMENT INCOME

Investment income plays a major role for medical liability insurers. Because medical liability insurance is a "long tail" line of insurance, insurers are able to invest the premiums they collect for substantial periods of time, and use the resulting investment income to offset premium needs. As can be seen on Exhibit 3, investment income has represented a substantial percentage of premium, and has played a major role in determining insurer financial performance. However, investment income as a percentage of premium has been declining in recent years primarily due to historic lows in market interest rates.

Contrary to the unfounded allegations of those who oppose effective tort reforms, medical liability insurers are primarily invested in high grade bonds and have not lost large amounts in the stock market. As can be seen in Exhibit 4, the carriers in the PIAA survey have been approximately 80% invested in bonds over the past seven years.

As shown on Exhibit 5, stocks have averaged only about 11% of cash and invested assets, thus precluding major losses due to swings in the stock market. Unlike stocks, high grade bonds are carried at amortized value on insurer's financial statements, with changes in market value having no effect on asset valuation unless the underlying securities must be sold.

The experience of the PIAA carriers is confirmed on an industry-wide basis through data obtained from the NAIC by Brown Brothers Harriman, a leading investment and asset management firm. Brown Brothers reports that "Over the last five years, the amount medical malpractice companies has invested in equities has remained fairly constant. In 2001, the equity allocation was 9.03%." As Exhibit 6 shows, medical liability insurers invested significantly less in equities than did all property casualty insurers.

Brown Brothers states that the equity investments of medical liability companies "...had returns similar to the market as a whole. This indicates that they maintained a diversified equity investment strategy.

The Brown Brothers report further states:

Since medical malpractice companies did not have an unusual amount invested in equities and what they did was invested in a reasonable market-like fashion, we conclude that the decline in equity valuations is not the cause of rising medical malpractice premiums.<sup>1</sup>

While insurer interest income has declined due to falling market interest rates, when interest rates decline, bond values increase. This has had a beneficial effect in keeping total investment income level when measured as a percentage of total invested assets. This is shown in Exhibit 7 below. Thus, the assertion that insurers have been forced to raise their rates because of bad investments is simply not true.

#### THE INSURANCE CYCLE

Opponents of effective tort reform claim that insurance premiums in constant dollars increase or decrease in direct relationship to the strength or weakness of the economy, reflecting the industry's investment performance. The researchers at Brown Brothers also tested this theory, and found no correlation between changes in generally accepted economic parameters (Gross Domestic Product (GDP) and 5-year treasury bond rates) with direct medical liability premiums written. In fact, Brown Brothers conducted 64 different regression analyses between the economy, investment yield, and premiums, and found no meaningful relationship. The report produced by Brown Brothers states:

Therefore, we can state with a fair degree of certainty that investment yield and the performance of the economy and interest rates do not influence medical malpractice premiums.<sup>2</sup>

#### INSURER SOLVENCY

A key measure of financial health is the ratio of insurance loss and loss adjustment expense (amounts spent to handle claims) reserve to surplus. This ratio has deteriorated (risen) for the PIAA carriers since 1999 to a point where it is approximately two times the level of surplus, as shown on Exhibit 8 below.

The relationship between reserves (amounts set aside to pay claims) and surplus is important, as it is a measure of the insurer's ability to contribute additional amounts to pay claims in the event that original estimates prove to be deficient. *At the current approximately two-to-one ratio, these carriers in aggregate are still in sound financial shape.* However, any further deterioration in surplus due to underwriting losses will cause a deterioration in this important benchmark ratio indicating an impairment in financial condition. Under current market conditions, characterized by increasing losses and declining investment interest income, the only way to increase surplus is through rate increases.

Net premiums written as compared to surplus is another key ratio considered by regulators and insurance rating agencies, such as A.M. Best. This statistic for the companies in the PIAA survey has also been deteriorating (rising) since 1999, showing a 50% increase in the two years ending in 2001. The premium-to-surplus ratio is a measure of the insurer's ability to write new business. In general, a ratio of one-to-one is considered to be the threshold beyond which an insurer has over-extended its capital available to support its underwritings.

<sup>1</sup>Did Investments Affect Medical Malpractice Premiums? Raghu Ramachandran, Brown Brothers Harriman, January 2003.

<sup>2</sup>Did Investments Affect Medical Malpractice Premiums? Raghu Ramachandran, Brown Brothers Harriman, January 2003.

As can be seen on Exhibit 9, this statistic has also deteriorated, and the carriers in aggregate are approaching one-to-one. As the carriers individually approach this benchmark, they will begin to decline new risks, causing further availability problems for insureds. Rate increases the carriers are taking also have an impact on this important ratio as well as new business written.

#### THE CAUSE OF THE CRISIS

The effects described in the previous pages were caused by the convergence of six driving factors making for *the perfect storm*, as follows:

- Dramatic long term paid claim severity rise
- Paid claim frequency returning and holding at high levels
- Declining market interest rates
- Exhausted reserve redundancies
- Rates becoming too low
- Greater proportion of large losses

The primary driver of the deterioration in the medical liability insurance industry performance has been paid claim severity, or the average cost of a paid claim, and their associated expenses. The National Association of Insurance Commissioners (NAIC) confirmed this in a February 7, 2003 letter to Senator Judd Gregg, which states in part: "The preliminary evidence points to rising loss costs and defense costs associated with litigation as the principal drivers of medical malpractice prices." (letter attached)

Exhibit 10 shows the average dollar amount paid in indemnity to plaintiffs on behalf of individual physicians since 1988. The mean payment amount has risen by a compound annual growth of 6.9% during this period, as compared to 2.6% for the Consumer Price Index (CPIu). The data for Exhibit 10, as well as that for slides which follow, comes from the PIAA Data Sharing Project. This is a medical cause-of-loss database, which was created in 1985 for the purpose of identifying common trends among malpractice claims. PIAA member companies use the database for risk management and patient safety purposes. To date, over 180,000 claims and suits have been reported to the database.

Allocated loss adjustment expenses (ALAE) for claims reported to the Data Sharing Project have also risen at alarming rates. ALAE are the amounts insurers pay to handle individual claims, and represent payments principally to defense attorneys, and to a lesser extent, expert witnesses. Average amounts paid for three categories of claims are shown below. As can be seen, the average amount spent for all claims in 2001 has risen to just under \$30,000.

One very troubling aspect of medical malpractice claims is the proportion of those filed which are ultimately determined to be without merit. Exhibit 12 shows the distribution of claims closed in 2001 as reported to the PIAA Data Sharing Project. Sixty-one percent of all claims filed against individual practitioners were dropped or dismissed by the court. An additional 5.7% were won by the doctor at trial. Only 33.2% of all claims closed were found to be meritorious, with most of these being paid through settlement. Of all claims closed, more than two-thirds had no indemnity payment to the plaintiff. When the claim was concluded at verdict, the defendant prevailed an astonishing 80% of the time. This data clearly shows that those attorneys trying these cases are woefully deficient in recognizing meritorious actions to be pursued to conclusion.

Analyses performed by the PIAA have shown that of all premium and investment income available to pay claims, only 50% ever gets into the hands of truly injured patients, with the remainder being principally paid to attorneys, both plaintiff and defense. Something is truly wrong with any system that consumes 50% of its resources to deliver the remainder to a small segment of those seeking remuneration.

A review of the average claim payment values for the latest year reported to the PIAA Data Sharing Project (2001) is revealing. As shown on Exhibit 13, the mean settlement amount on behalf of an individual defendant was just over \$299,000. Most medical malpractice cases have multiple defendants, and thus, these values are below those, which may be reported on a per case basis. The mean verdict amount last year was almost \$497,000 per defendant.

Exhibit 14 shows the mean expense payment for claims by category of disposition. As can be seen, the cost of taking a claim for each doctor named in a case all the way through trial is fast approaching \$100,000. Exhibit 15 shows the distribution of claims payments at various payment thresholds. It can be readily seen that the number of larger payments are growing as a percentage of the total number of payments.

This is especially true for payments at or exceeding \$1 million, which comprised almost eight percent of all claims paid on behalf of individual practitioners in 2001

(Exhibit 16). This percentage has doubled in the past four years, and clearly demonstrates why insurers are facing dramatic increases in the amounts they have to pay for reinsurance. While medical liability insurers are reinsured by many of the same companies having high losses from the World Trade Center disaster, their medical liability experience was rapidly deteriorating prior to September 11, 2001.

In addition to rising claim severity, like all other investors, medical liability insurers have faced declining market interest rates. Eighty percent of PIAA insurers' investments are placed in high-grade bonds. Exhibit 17 shows the long-term decline in high-grade bond earnings. As can be seen, this is not a recent phenomenon, but a long term trend.

Critics of the medical liability insurance industry say that insurers' reliance on investment income to offset premiums has caused turmoil in the marketplace, implying that the use of investment income is a bad thing. Nothing could be further from the truth. If insurers did not ever use investment income to offset premium needs, then rates would always be 30—40% higher than otherwise necessary. The role market interest rates play in determining pricing in medical liability insurance (and other lines as well) is a fact of life which we cannot control.

#### THE ANSWER

Medical liability insurers and their insureds have faced dramatic long-term rises in paid claim severity, which is now at historically high levels. Paid claim frequency (the number of paid claims) is currently remaining relative constant, but has risen significantly in some states. While interest rates will certainly rise and fall in future years, nothing has been done over the past three decades to stem the ever-rising values of medical malpractice claim payments or reduce the number of meritless claims clogging up our legal system at great expense—except in those few states that have effective tort reforms. In many states not having tort reforms, costs have truly become excessive, and insurers are forced to set rates at levels beyond the abilities of doctors and hospitals to pay. States having tort reforms, such as California, provide a compelling example that demonstrates how such reforms can lower medical liability costs and still provide adequate indemnification for patients harmed as a result of the delivery of health care.

The following reforms are those which the PIAA advocates be adopted at the federal level, which we also feel should be the standard for any state reforms enacted. They are based on the reforms found in the Medical Injury Compensation Reform Act (MICRA) which became effective in California in 1976 and which have been successful in compensating California patients and ensuring access to the health care system since their enactment.

The keystone of the MICRA reforms is the \$250,000 cap on non-economic damages (pain and suffering) on a per-incident basis. Under MICRA, injured patients receive full compensation for all quantifiable damages, such as lost income, medical expenses, long-term care, etc. In addition, injured patients can get as much as one-quarter million dollars for pain and suffering. Advising juries of economic damages that have already been paid by other sources serves to reduce double payment for damages. An important component of MICRA is a reasonable limitation on plaintiff attorney contingency fees, which can be 40% or more of the total amount of the award. Under MICRA, a trial lawyer must be satisfied with only a \$220,000 contingency fee for a \$1 million award.

A Gallup poll published on February 5, 2003 by the National Journal indicates that 57% of adult Americans feel there are too many lawsuits against doctors, and 74% feel that we are facing a major crisis regarding medical liability in health care today. Seventy-two percent of respondents favored a limit on the amount that patients can be awarded for their emotional pain and suffering. Only the trial lawyers and their front groups disagree, seeing their potential for remuneration being reduced. Especially displeasing to them is MICRA's contingency fee limitation, which puts more money in the hands of the injured patient (at no cost reduction to the insurer).

The U.S. House of Representatives adopted legislation containing tort reforms similar to MICRA, including a \$250,000 cap on non-economic damages, for the seventh time in September of last year. HR 4600, known as the HEALTH Act, was introduced and adopted on a bi-partisan basis. The Congressional Budget Office (CBO) conducted an extensive review of the provisions of HR 4600, and reported to Congress that if the reforms were enacted, "...premiums for medical malpractice insurance ultimately would be an average of 25 percent to 30 percent below what they would be under current law."

The CBO found that HR 4600 reforms would result in savings of \$14.1 billion to the federal government through Medicare and other health care programs for the

period 2004–2012. An additional \$7 billion of savings would be enjoyed by the states through their health care programs. The CBO's analysis did not consider the effects that federal tort reform would have on reducing the incidence of defensive medicine, but did acknowledge that savings were likely to result.

The US Department of Health and Human Services published a report on July 24, 2002, which evaluated the effects of tort reforms in those states that have enacted them. As stated in Exhibit 20, HHS found that practitioners in states with effective caps on non-economic damages were currently experiencing premium increases in the 12–15% range, as compared to average 44% increases in other states.

Annual data published by the National Association of Insurance Commissioners (NAIC) also documents the savings California practitioners and health care consumers have enjoyed since the enactment of MICRA over 25 years ago. As shown in Exhibit 21, total medical liability premiums reported to the NAIC since 1976 have grown in California by 167%, while premiums for the rest of the nation have grown by 505%. These savings can only be attributed to MICRA.

These savings are clearly demonstrated in the rates charged to California doctors as shown in Exhibit 22. Successful experience in California and other states makes it clear that MICRA style tort reforms do work without lowering health care quality or limiting access to care.

#### PROP 103 HAD NO EFFECT ON CALIFORNIA MEDICAL LIABILITY PREMIUMS

In an effort to derail desperately needed tort reforms as described above, the Association of Trial Lawyers of America and related individuals and groups have stated that the beneficial effects of MICRA as shown on Exhibit 21 are due to Proposition 103, a ballot initiative passed in 1988 aimed primarily at controlling auto insurance costs. The ballot initiative passed by a 51% majority vote, with voters in only 7 of California's 58 counties approving the measure. The major changes made by Prop 103 include:

- Making the insurance commissioner of California an elected, rather than appointed, official;
- Giving the insurance commissioner authority to approve rate changes before they can take effect;
- Requiring insurers to reduce rates by 20 percent from their levels on November 8, 1987;
- Requiring auto insurance companies to offer a 20 percent "good driver discount."
- Requiring auto insurance rates to be determined primarily by four factors;
- Allowing for payment of "intervenor fees" to outside groups that intervene in hearings conducted by the Department of Insurance<sup>3</sup>.

Medical liability insurers were not the intended target of Prop 103, but were covered by the resulting regulations. However, Prop 103 did not have any substantive effect on reducing medical liability insurance rates. Prop 103 did have the effect of freezing most insurance rates in California until as late as 1994.<sup>4</sup> This all came at a time when medical liability insurers across the nation were seeing their rates level off or even decline.

Prop 103 added a provision to the California Insurance Code at Section 1861.01, which required insurers to roll back their rates to 20 percent lower than those in effect on November 8, 1987. However, this is not what happened to medical malpractice insurers.

One major California insurer, the NORCAL Mutual Insurance Company reached the very first consent agreement of any insurer with the California Department of Insurance in November of 1991. To satisfy the requirements of Prop 103, NORCAL was specifically permitted to declare a one-time 20% return of premium for policyholders insured between November 8, 1988 and November 8, 1989 as a dividend by March 31, 1992. NORCAL was not required to roll back its rates as a result of Prop 103. As NORCAL was already paying dividends exceeding 20% per year during the period in question, no additional monies were returned to policyholders as a result of Prop 103. The experience of other California physician owned companies, such as The Doctors' Company and the Medical Insurance Exchange of California, was similar to that of NORCAL. Even if California medical liability insurers had been re-

<sup>3</sup>Ironically, the Proposition 103 Enforcement Project headed by Harvey Rosenfeld, a self-proclaimed consumer advocate who led the fight for the adoption of Prop 103, has received almost \$1.5 million in intervenor fees through 1997. In total, "consumer organizations" and individuals have received over \$7.1 million in intervenor fees and administrative costs through 1997. Source: Personal Insurance Federation of America.

<sup>4</sup>Background on Insurance Reform—A Detailed Analysis of California Proposition 103,.

quired to reduce rates by 20%, this in no way could explain the wide gap in experience shown on Exhibit 21.

#### CONCLUSION

Increasing medical malpractice claim costs, on the rise for over three decades, have finally reached the level where the rates that insurers must charge can no longer be afforded by doctors and hospitals. These same doctors and hospitals cannot simply raise their fees, which are limited by government or managed care companies. Many doctors will face little choice other than to move to less litigious states or leave the practice of medicine altogether.

Legislators are now challenged with finding a solution to the medical liability insurance affordability and availability dilemma—a problem long in coming that has truly reached the crisis stage. The increased costs being experienced by insurers (largely owned/operated by health care providers) are real and documented. It is time for Congress to put an end to the wastefulness and inequities of our tort legal system, where only 50% of the monies available to pay claims are paid to indemnify the only 30% of claims filed with merit and the expenses of the remainder. The system works fine for the legal profession, which is why trial lawyers and others fight so hard to maintain the status quo.

The PIAA strongly urges members of the House to pass effective federal health care liability reform, thereby stopping the exodus of health care professionals and institutions which can no longer afford to fund an inequitable and inefficient tort system which benefits neither injured plaintiffs or the health care community.

**INSERT OFFSET FOLIOS 43 TO 52 HERE**

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

*February 7, 2003*

Honorable JUDD GREGG

*Chairman, Committee on Health, Education, Labor, and Pensions*

*United States Senate*

*Washington, DC 20610-6300*

DEAR CHAIRMAN GREGG: On behalf of the National Association of Insurance Commissioners (NAIC), I am pleased to respond to your letter of January 31, 2003 requesting information on medical malpractice insurance. Many states are experiencing escalating premium costs for this critical insurance coverage for doctors, while also encountering problems of availability and insufficient capacity to support a healthy competitive market.

State insurance commissioners share the concerns you and other Members of Congress are raising about improving the availability and affordability of medical malpractice insurance. We are vested with the responsibility of protecting the rights of consumers and assuring that insurers remain financially solvent and able to meet their claims obligations. While the recent trends in some states over limited availability and escalating premiums make oversight critical, we would caution that any reforms be considered carefully, especially in recognition of reforms already enacted in several states.

In September 2002, we established a Market Conditions Working Group to look at these issues more closely and based upon that review make recommendations to regulators. The working group has scheduled a public hearing on Saturday, March 8, 2003. We are hopeful this hearing and other efforts will help guide state and federal policymakers as they work to explore potential solutions. We will look forward to sharing with you the results of this hearing.

Our responses to the questions in your letter are as follows:

- (1) Are medical malpractice insurance rates subject to state law prohibitions on excessive, inadequate, or unfairly discriminatory rates?

Almost all states have rating laws for property and casualty insurance, including medical malpractice. These rating laws require that insurance rates not be excessive, inadequate, or unfairly discriminatory.

- (2) If a state determines that a rate is excessive, inadequate, or unfairly discriminatory, does the insurance regulator have the authority to reject or modify such a rate?

If a state receives a filing from an insurer that contains a rate that is believed to be out of compliance with the statutory rating standards, there are remedies available to address the problem. The most common regulatory approach available to insurance regulators is the ability to order a hearing on the non-complying rate. In states with prior approval laws, the commissioner generally has



authority to disapprove the non-complying rate, however the insurer is generally provided an opportunity for a hearing if it disagrees with the commissioner's decision. Only in rare instances does an insurance commissioner have authority to unilaterally modify a filed rate. Because of extremely high loss ratios in many states, regulator concerns have been with rate inadequacy, and not excessiveness or unfair discrimination.

- (3) If states do have this authority, can you provide any examples where a state insurance regulator has rejected or modified an excessive or unfairly discriminatory medical malpractice insurance rate?

We are not aware of any recent state actions in this regard. State insurance regulators generally do have the authority to prevent anti-trust activities by insurers. These state laws are based on the NAIC model rating laws, which contain the following provisions.

"No insurer or advisory organization shall attempt to monopolize, or combine or conspire with any other person to monopolize an insurance market or engage in a boycott, on a concerted basis, of an insurance market."

"No insurer shall agree with any other insurer or with an advisory organization to mandate adherence to or to mandate use of any rate, prospective loss cost, rating plan, rating schedule, rating rule, policy or bond form, rate classification, rate territory, underwriting rule, survey, inspection or similar material, except as needed to facilitate the reporting of statistics to advisory organizations, statistical agents or the commissioner. The fact that two or more insurers, whether or not members or subscribers of an advisory organization, use consistently or intermittently the same rates, prospective loss cost, rating plans, rating schedules, rating rules, policy or bond forms, rate classifications, rate territories, underwriting rules, surveys or inspections or similar materials is not sufficient in itself to support a finding that an agreement exists."

"No insurer or advisory organization shall make any arrangement with any other insurer, advisory organization, or other person which has the purpose or effect of unreasonably restraining trade or lessening competition in the business of insurance."

States generally have adopted the NAIC model law provisions or equivalent provisions, thus comparable authority currently exists. Again, due to extremely high loss ratios, the concern has been with rate inadequacy.

- (4) The Leahy legislation presumes that medical malpractice insurance carriers are engaging in "price fixing, bid rigging, and market allocation." Does the NAIC, or any of your members have evidence that medical malpractice insurance carriers are engaging in these types of criminal behaviors? If so, could you detail that information for us?

No. To date, insurance regulators have not seen evidence that suggests medical malpractice insurers have engaged or are engaging in price fixing, bid rigging, or market allocation. The preliminary evidence points to rising loss costs and defense costs associated with litigation as the principal drivers of medical malpractice prices. A July 2002 report prepared by the Department of Health and Human Services also cites the impact of litigation and defense costs on this line of insurance.

- (5) Notwithstanding the McCarran-Ferguson exemption from federal anti-trust laws, do state insurance regulators and attorneys general have the authority to prevent "price fixing, bid rigging or market allocations" under current state law? If so, could you explain the deficiencies in those laws and provide us with proposed remedies?

As noted in the previous question, states have strong laws that prohibit price-fixing and anti-competitive practices by insurers. The sharing of loss data among insurers is permitted, however, because it is necessary to encourage competition by giving potential new entrants to the marketplace and smaller insurers enough underwriting and rate-setting information to enter and remain viable in the medical malpractice marketplace. Again, the evidence points to high loss ratios, not price-fixing, as the primary driver of escalating premiums.

- (6) What percentage of the medical malpractice insurance market is composed of non-profit physician-owned mutuals? What incentive or incentives, if any, do you think these types of medical malpractice carriers face that would cause them to engage in "price fixing, bid rigging or market allocations?"

Non-profit physician-owned mutual insurers have developed in response to market availability concerns. Since the owners of these mutuals are also the customers, it would appear on the surface that market allocation might be occurring. Careful inspection will show that a mutual insurer is concerned with its policyholders' interests. Since each policyholder is also an owner of the com-

pany and the company is a non-profit entity, the goal of the mutual insurer is to deliver medical malpractice insurance to its policyholder/owners as inexpensively as possible. To do otherwise would contradict the goals of the mutual and jeopardize its non-profit status

- (7) Finally, if the Leahy legislation were to be enacted, would it lower the underlying medical malpractice claims costs and stabilize medical liability insurance premiums? If yes, in what way would it do so?

No, we do not believe enactment of the Leahy legislation as originally drafted would change the underlying costs of malpractice claims or premiums. We now understand this language is being modified. The reason insurers are not writing, or are pulling back from medical malpractice insurance, is because there are many other lines of insurance that offer more opportunities for profit at a lower risk. The uncertainties and historical return in this line of business lead many commercial insurers to commit capital in other lines of commercial insurance. It is our experience this market will remain volatile in some states until such time as claims costs stabilize.

Finally, while we are seeing difficult market conditions in some states, it is by no means widespread in all states. Like all insurance markets, medical malpractice insurance markets vary from state to state. However, the cost drivers in all states are closely linked to claims losses.

I hope this information is helpful, and we look forward to being of assistance as your Committee continues its review of these issues. The NAIC and its members stand ready to provide whatever data and resources we have available to help Congress and the states improve the market for medical malpractice insurance.

Sincerely,

MIKE PICKENS

*Commissioner of Insurance, Arkansas, President, NAIC*

**INSERT OFFSET FOLIOS 53 TO 62 HERE**

Mr. BILIRAKIS. Thank you, Mr. Smarr.  
Dr. Palmisano.

**STATEMENT OF DONALD J. PALMISANO**

Mr. PALMISANO. Good morning. I am Donald Palmisano, president-elect of the American Medical Association and a surgeon in New Orleans. The policy of the American Medical Association is decided through a Democratic policymaking process involving physician delegates representing every State, nearly 100 national specialty medical societies, Federal service agencies and other group sections. AMA policy dictates support for national medical liability reform. My testimony represents this policy. Thank you, Mr. Chair, for inviting the AMA to participate in today's hearing. I want to express our gratitude to you, Representatives Greenwood, Cox and Tauzin, and other cosponsors of H.R. 5 for your efforts to bring reasonable reforms to our broken medical liability system.

Mr. Chair, you know that our health care system is facing a crisis when patients have to leave their State to receive urgent surgical care or when pregnant women cannot find an OB-GYN physician to monitor their pregnancy and deliver their baby, or when community health center have to reduce their services or close their doors because of liability insurance concerns. You know that our health care system is facing a crisis when physicians and other health care professionals believe they work in a culture of fear rather than a culture of safety, or when efforts to improve patient safety and quality are stifled because of lawsuit fears.

Escalating jury awards and the high cost of defending against lawsuits, even meritless claims, are causing medical liability insurance premiums to soar. Over the past 2 years, many physicians have been hit with medical liability premium increases of 25 to 400 percent as reports show the average jury award reaching \$3.5 million.

As medical liability insurance becomes unaffordable or unavailable, physicians are forced to close their practices or drop vital services seriously affecting patient access to care. Twelve states are currently in a crisis, and we are concerned that more States will be in a full-blown crisis in the near future. Several recent government and private sector reports confirm that the cause of the liability crisis is the unrestrained escalation of jury awards. Opponents claim that the soaring medical liability insurance premiums are the result of declining investments in the insurance industry, and that liability reforms do not stabilize the insurance markets. These claims are misleading based on flawed analysis and contrary to the facts.

AM Best recently reported that medical liability insurers have approximately 80 percent of their investments in the bond market, and investment yields have been stable and positive since 1997. Other credible sources, including Brown Brothers Harriman's recent study, conclude that "investment did not precipitate the current crisis."

In Florida, a nonpartisan taskforce recently found the recommendation that the greatest long-term impact on health care provider liability insurance rates, and thus eliminate the crisis of availability and affordability of health care in Florida, is a

\$250,000 cap on non-economic damages. This limit on non-economic damages has worked in California, and it can work nationwide. The National Association of Insurance Commissioners, NAIC, studied 24 years of premiums in California. They found that premiums across the Nation increased three times faster than premiums in California.

In addition, studies show that the tort system is an extremely inefficient mechanism for compensating patients, returning less than 50 cents on the dollar already to claimants, and less than 22 cents for actual economic losses.

Mr. Chair, as you have recognized, the time for action is past due. We must act now to fix our broken medical liability system. That is why the AMA is here supporting H.R. 5, and that is why we join with numerous members of a broad based coalition known as the Health Coalition on Liability and access to urge this Congress to promptly reform the medical liability system. We must bring common sense back to our courtrooms so that patients have access to their physicians, whether in emergency rooms, delivery rooms or operating rooms. In effect, we need to have balance. We need to make sure that all of the patients in America have access to care. Thank you.

[The prepared statement of Donald J. Palmisano follows:]

PREPARED STATEMENT OF DONALD J. PALMISANO, ON BEHALF OF AMERICAN MEDICAL ASSOCIATION

On behalf of the physician members of the American Medical Association (AMA), I appreciate the opportunity to testify before you today regarding an issue that is seriously threatening the availability of and access to quality health care for patients. I would especially like to express our gratitude to you, Mr. Chair, and Representatives Jim Greenwood (R-PA), Chris Cox (R-CA), Billy Tauzin (R-LA), and other cosponsors of H.R. 5 for providing a much needed focus for action at the national level.

I am Donald Palmisano, MD, JD, President-elect of the AMA and a general and vascular surgeon from New Orleans, LA. The policy of the AMA is decided through its democratic policy-making process in the AMA House of Delegates, which meets twice a year. Our House is comprised of physician delegates representing every state, nearly 100 national medical specialty societies, federal service agencies (including the Surgeon General of the United States), and six sections representing hospital and clinic staffs, resident physicians, medical students, young physicians, medical schools, and international medical graduates. AMA policy dictates support for national medical liability reform. In particular, the AMA supports H.R. 5, the HEALTH Act.

Mr. Chair, you know that our health care system is facing a crisis when patients have to leave their state to receive urgent surgical care. You know that our health care system is facing a crisis when pregnant women cannot find an OB/GYN to monitor their pregnancy and deliver their baby. You know that our health care system is facing a crisis when community health centers have to reduce their services or close their doors because of liability insurance concerns. You know that our health care system is facing a crisis when dedicated professionals, who have trained for years, want to give up the work of a lifetime and retire. You know that our health care system is facing a crisis when physicians and other health care professionals believe they work in a culture of fear, rather than a culture of safety. You know that our health care system is facing a crisis when efforts to improve patient safety and quality are stifled because of lawsuit fears. An unrestrained medical liability system is driving our health care system into crisis.

As you have recognized, the time for action is past due. Physicians across the country are making decisions now, and more and more patients are wondering, "Will their doctor be there?" We must act now to fix our broken medical liability system. That is why we are here supporting H.R. 5, and that is why we join with numerous other members of a broad-based coalition known as the Health Coalition for Liability and Access to urge this Congress to promptly reform the medical liability system.

## ACCESS TO CARE IS AT RISK

The crisis facing our nation's medical liability system has not waned—in fact, it is getting worse. Escalating jury awards and the high cost of defending against lawsuits, even frivolous ones, have caused medical liability insurance premiums to reach unprecedented levels. As a result, a growing number of physicians can no longer find or afford liability insurance. Over the past two years, many physicians have been hit with medical liability premium increases of 25 to 400 percent. Some hospitals have seen premiums increase 140 percent in the same time period.

The most troubling aspect of this crisis is its impact on patients. As insurance becomes unaffordable or unavailable, physicians are being forced to close their practices or drop vital services—all of which seriously impede patient access to care. Emergency departments are losing staff and scaling back certain services such as trauma units. Many obstetrician-gynecologists and family physicians have stopped delivering babies, and some advanced and high-risk procedures (such as neurosurgery) are being postponed because physicians can no longer afford or even find the liability insurance they need to practice. According to the American Hospital Association's 2002 TrendWatch 1, more than 26% of health care institutions have reacted to the liability crisis by cutting back on services, or even eliminating some units.

**A 2002 survey conducted by Wirthlin Worldwide shows that 78 percent of Americans say they are concerned about access to care being affected because doctors are leaving their practices due to rising liability costs.**

Virtually every day for the past year there has been at least one major media story on the plight of American patients and physicians as the liability crisis reaches across the country. Access to health care is now seriously threatened in states such as Florida, Georgia, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington, and West Virginia. On top of this, we expect at least five more states to be in a full blown crisis in the near future, with a crisis looming in at least 26 other states. A sample of media reports in the appendices to this testimony illustrates the problems faced by patients and physicians in some of these states—problems many other states will face if effective tort reforms are not enacted.

**We must bring common sense back to our courtrooms so that patients have access to their emergency rooms, delivery rooms, operating rooms, and physicians' offices.**

## THE LITIGATION SYSTEM IS CAUSING THE CRISIS

The primary cause of the growing liability crisis is the unrestrained escalation in jury awards that are a part of a legal system that in many states is simply out of control. While there have been several articles published since the mid-1990s indicating that increases in jury awards lead to higher liability premiums, in the last year a growing number of government and private sector reports show that increasing medical liability premiums are being driven primarily by increases in lawsuit awards and litigation expenses.

In his State of the Union Address last month, President Bush stressed that we all are threatened by a legal system that is out of control. The President stated that "Because of excessive litigation, everybody pays more for health care and many parts of America are losing fine doctors." The President's remarks are substantiated in several recent government and private sector reports—reports making clear that the medical liability litigation system in the United States has evolved into a "lawsuit lottery," where a few patients and their lawyers receive astronomical awards and the rest of society pays the price as access to health care professionals and services are reduced.

*Recent Federal Government Reports*

In a July 2002 report released by the U.S. Department of Health and Human Services (HHS), the federal government concluded that the excesses of the litigation system are threatening patients' access to health care. This federal government report states that insurance premiums are largely determined by the litigation system, and that the litigation system is inherently costly, unpredictable, and slow to resolve claims. **Just to defend a claim now costs on average over \$24,000. Further, the fact that about 70 percent of claims end with no payment to the patient indicates the degree to which substantial economic resources are being squandered on fruitless legal wrangling—resources that could be used to reduce health costs so that more Americans could find health insurance.**

Even when there is a large award in favor of an injured patient, a large percentage of the award never reaches the patient. Attorney contingent fees, added with court costs, expert witness costs, and other “overhead” costs, can consume 40-50 percent of the compensation meant to help the patient.

On September 25, 2002, HHS issued an update on the medical liability crisis. This update reported on the results of a survey conducted by Medical Liability Monitor (MLM), an independent reporting service that tracks medical professional liability trends and issues. According to MLM, the survey determined that the crisis identified in HHS’s July report had become worse. The federal government reported that:

The cost of the excesses of the litigation system are reflected in the rapid increases in the cost of malpractice insurance coverage. Premiums are spiking across all specialties in 2002. When viewed alongside previous double-digit increases in 2000 and 2001, **the new information further demonstrates that the litigation system is threatening health care quality for all Americans as well as raising the costs of health care for all Americans.** (emphasis added)

This federal government update further highlights that liability insurance rates are escalating faster in states that have not established reasonable limits on unquantifiable and arbitrary non-economic damages. The government’s report states that:

... 2001 premium increases in states without litigation reform ranged from 30%-75%. In 2002, the situation has deteriorated. **States without reasonable limits on non-economic damages have experienced the largest increases by far, with increases of between 36%-113% in 2002.** States with reasonable limits on non-economic damages have not experienced the same rate spiking. (emphasis added)

HHS also compared the range of physician liability insurance premiums for certain specialties in California, which has established reasonable limits on awards for non-economic damages, to the premiums in states that have not enacted similar limits. The results reveal how excessive awards for non-economic damages affect premiums. For example, in 2002, OB/GYNs in California paid up to \$72,000 in medical liability premiums. In Florida, which does not limit non-economic damage awards, OB/GYNs paid up to \$211,000 for liability coverage.

Further, a 2002 Congressional Budget Office study on H.R. 4600 (107th Congress), which included a limitation on non-economic damages, asserts that:

CBO’s analysis indicated that certain tort limitations, primarily caps on awards and rules governing offsets from collateral-source benefits, effectively reduce average premiums for medical malpractice insurance. Consequently, CBO estimates that, in states that currently do not have controls on malpractice torts, H.R. 4600 would significantly lower premiums for medical malpractice insurance from what they would otherwise be under current law.

In Florida, as indicated in the example given above, medical liability premiums are among the highest in the nation. The situation in Florida has become so dire that Governor Bush created a special Task Force to examine the availability and affordability of liability insurance. This Task Force held ten hearings over a five month period and received extensive testimony and information from numerous, diverse sources.

Among the many findings in its report released on January 29, 2003, **the Governor’s Task Force found that the level of liability claims paid was the main cause of the increases in medical liability insurance rates.** The Task Force ultimately concluded that “the centerpiece and the recommendation that will have the greatest long-term impact on healthcare provider liability insurance rates, and thus eliminate the crisis of availability and affordability of healthcare in Florida, is a \$250,000 cap on non-economic damages.”

#### *Recent Private Sector Reports*

Evidence that the litigation system is broken, and that the medical liability crisis is growing, is further established in a study released by Tillinghast-Towers Perrin on February 11, 2003. Tillinghast reported that “The cost of the U.S. tort system grew by 14.3% in 2001, the highest single-year percentage increase since 1986,” which is “equivalent to a 5% tax on wages.” This is the only study that tracks the cost of the U.S. tort system from 1950 to 2001 and compares the growth of tort costs with increases in various U.S. economic indicators. Some of the key findings of this study are stunning:

- The U.S. tort system is a highly inefficient method of compensating injured parties, returning less than 50 cents on the dollar to people it is designed to help and returning only 22 cents to compensate for actual economic loss.

- As of 2001, U.S. tort costs accounted for slightly more than 2% of GDP, signaling an increase after a 13-year decline in the ratio of tort costs to GDP.
- While the cost of the U.S. tort system has increased one hundred fold over the last fifty years, GDP has grown by a factor of only 34.
- **Medical malpractice costs have risen an average of 11.6% a year since 1975 in contrast to an average annual increase of 9.4% for overall tort costs, outpacing increases in overall U.S. tort costs.**

The study also adds that "These trends continued in 2002, with no sign of abatement in the near future." In a press release accompanying this study, a Tillinghast principal stated that, "Absent sweeping tort reform measures, we expect most of these trends to continue in 2003 and beyond."

In a 2001 report by Jury Verdict Research, data show that in just a one year period (between 1999 and 2000) the median jury award increased 43 percent. Further, median jury awards for medical liability claims grew at 7 times the rate of inflation, while settlement payouts grew at nearly 3 times the rate of inflation. Even more telling, however, is that *the proportion of jury awards topping \$1 million increased from 34 percent in 1996 to 52 percent in 2000. More than half of all jury awards today top \$1 million, and the average jury award has increased to about \$3.5 million.*

These are just a few examples of growing evidence that reveal that out-of-control jury awards are inexorably linked to the severe increases in medical liability insurance premiums. It is clear that corrective action through federal legislation is urgently needed.

#### *Blaming Insurance Industry Investments Is A Red Herring*

Organizations opposing H.R. 5 have claimed that soaring medical liability insurance premiums are the result of declining investments in the insurance industry, and that liability reforms do not stabilize the insurance market. The reports discussed above, as well as several other authoritative and credible studies, reveal such claims to be misleading, based on flawed analysis, and contrary to the facts.

Last month, Brown Brothers Harriman & Co. (BBH) released a report ("Did Investments Affect Medical Malpractice Premiums?") that analyzed the impact of insurers' asset allocation and investment income on the premiums they charge. **BBH concluded that there is no correlation between the premiums charged by the medical liability insurance industry, on the one hand, and the industry's investment yield, the performance of the U.S. economy, or interest rates, on the other hand.**

In addition, on February 4, 2003, BBH released an addendum to this study that analyzed National Association of Insurance Commissioners (NAIC) data to determine whether investment gains by medical liability insurance companies declined in the recent bear market. BBH asked the question: "Did medical malpractice companies raise premiums because they had come to expect a certain percentage gain that was not achieved due to market conditions?" BBH determined that the decline in equities (which are a small percentage of insurance company investments) was more than offset by the capital gains by bonds (which make up a substantial part of insurance company investments) due to a decline in interest rates. **BBH concluded that "investments did not precipitate the current crisis."**

BBH's findings are corroborated by other recent reports. On September 25, 2002, HHS released an update on the medical liability crisis addressing claims that the crisis is caused by the management practices of the insurance industry. HHS concluded that such claims are not supported by facts, stating **"Comparisons of states with and without meaningful medical liability reforms provide clear evidence that the broken medical litigation system is responsible."**

In addition, a summary of medical liability insurer annual statement data in A.M. Best's Aggregates & Averages, Property-Casualty, 2002 edition shows that the investment yields of medical malpractice insurers have been stable and positive since 1997. A.M. Best reports that medical liability insurers have approximately 80% of their investments in the bond market. Also, **recent NAIC data show that physicians' medical liability insurance premiums between 1976-2000 have risen 167% in California (which established effective liability reforms in 1975) compared to 505% in the rest of the United States.**

The report on which H.R. 5 opponents base most of their speculations, produced under the direction of J. Robert Hunter for the Americans for Insurance Reform (AIR), is flawed in a number of ways. The AIR/Hunter study purports that there is no current explosion in medical liability insurance payouts, and that the explosion in medical liability insurance premiums is due to the insurance underwriting cycle. While *medical liability insurance premiums, medical liability award payouts, and tort law factors* differ across states, the premium and payout data presented in



AIR's report are at the national level. One cannot use national data to draw valid conclusions about how state-specific changes in premiums may be related to state-specific changes in payouts. **Conclusions about what has or has not caused recent premium escalation without accounting for the state-level factors listed above are unsupportable.**

In addition to claiming that the current medical liability crisis is an insurance issue, there have been attempts to argue that medical liability insurance premium rates in California have remained stable because of Proposition 103, not because of the successful medical liability reforms (known as MICRA—discussed later) that have been in place in California since 1975. Such claims are misguided. Proposition 103, also known as the Insurance Rate Reduction and Reform Act, applies to all lines of insurance, not just medical liability insurance. It was passed as an initiative by the voters in 1988 (thirteen years after MICRA), yet did not take effect until 1989. This is when the state's high court struck down its rate rollback provisions while maintaining the remainder of the law.

Proposition 103 implemented a basic standard that "no rate shall be approved or remain in effect which is excessive, inadequate, unfairly discriminatory or otherwise in violation of this chapter." However, Proposition 103 provides that "every insurer which desires to change any rate shall file a complete rate application with the commissioner." Proposition 103 also requires that the Department of Insurance grant a hearing for a challenge to any increase above 15 percent for commercial lines of insurance.

According to Californians Allied for Patient Protection, "Insurers have regularly applied for and obtained significant rate increases in all lines of insurance, except medical liability where MICRA has kept the rates from rising astronomically. Between September and the end of October, 2002, for instance, the Insurance Department approved more than 75 applications for double-digit increases in insurance rates." **None of these approved increases included medical liability insurance.** This illustrates that Proposition 103 is not responsible for keeping medical liability premiums down. Rather, as we discuss later, it is MICRA that has been the force behind California's success.

Such misdirected claims as discussed above are a disservice to patients who are losing access to health care services, and an affront to the physicians and other health care professionals who dedicate their lives to healing and caring for the sick and working to find ways to improve the quality of care. America's medical liability crisis is too serious and the consequences of inaction too grave for the public and Congress to use anything but the facts to make decisions about reform. In short, these claims are counterproductive to the debate on resolving the medical liability crisis.

#### FEDERAL SOLUTION

The medical liability crisis is a growing national problem that requires a national solution. If the crisis was just a matter of physicians obtaining or affording medical liability insurance in one state, we might agree that a national approach would not necessarily be required. However, the problem goes far beyond physicians and other health care professionals and institutions. The medical liability crisis has become a serious problem for patients and their ability to access health care services that would otherwise be available to them, including services provided to Medicare and Medicaid patients.

Also, the premise that it is within the ability of every state to enact legislation to effectively resolve their respective medical liability crisis has been shattered by the fact that many state liability reform laws have been nullified by activist state courts or stripped of their most effective provisions under state constitutions that limit reforms. Taking into consideration that studies show the litigation system to be an ineffective, and often unfair, mechanism for resolving medical liability claims, we believe that the time is ripe for a uniform, federal approach to resolving the liability crisis.

Moreover, there is a direct and compelling federal interest in reforming our out-moded medical liability system. According to estimates by HHS, altogether medical liability adds \$60 billion to \$108 billion to the cost of health care each year. This means higher health insurance premiums and higher medical costs for all Americans, and especially for the federal government given that one-third of the total health care spending in our country is paid by the Medicare and Medicaid Programs. Further, HHS estimates that excessive medical liability adds \$47 billion annually to what the federal government pays for Medicare, Medicaid, the State Children's Health Insurance Program, Veterans' Administration health care, health care for federal employees, and other government programs.

## THE LIABILITY CRISIS AND PATIENT SAFETY

The AMA's policy is to be part of the solution to improving patient safety and quality. The AMA believes that one preventable error is one error too many. In fact, the AMA helped launch the National Patient Safety Foundation (NPSF) in 1996 to address patient safety issues, well before publication of the IOM report. The NPSF's approach is to create a culture of cooperative learning and mutual improvement, as opposed to a culture of shame and blame.

Quality of care improves when there is greater access to physicians and health care services. A culture of safety requires a legal environment that encourages professionals and organizations to work together to identify problems in providing care, evaluate the causes, and use that information to improve care for all patients. An over-litigious system is anathema to building a strong and effective national patient safety program.

Under our current liability system, the reality of being sued is daunting to just about everyone in the medical community. A 2002 Harris Interactive study (*The Fear of Litigation Study—The Impact on Medicine*) illustrates just how detrimental the litigious nature of our society is to physicians and other health care professionals. This study reveals the extent to which the fear of litigation affects the practice of medicine and the delivery of health care—"From the increased ordering of tests, medications, referrals, and procedures to increased paperwork and reluctance to offer off-duty medical assistance, the impact of the fear of litigation is far-reaching and profound."

The study shows, among other things, that more than three-fourths (76%) of physicians believe that concern about medical liability litigation has negatively affected their ability to provide quality care in recent years, and nearly all physicians and hospital administrators feel that unnecessary or excessive care is provided because of litigation fears. It also shows that an overwhelming majority of physicians (83%) and hospital administrators (72%) do not trust the current system of justice to achieve a reasonable result to a lawsuit.

The Harris study found that a majority (59%) of physicians believe ("a lot") that the fear of liability discourages open discussion and thinking about ways to reduce health care errors. The AMA has long believed that health professionals and organizations should be encouraged to report and evaluate health care errors and to share their experiences with others in order to prevent similar occurrences. However, this "culture of fear" caused by our over-litigious society suppresses such information.

The AMA strongly supports the principle underlying the 1999 Institute of Medicine (IOM) report entitled, *To Err is Human: Building a Safer Health System*, that the health care system needs to transform the existing culture of blame and punishment, which suppresses information about errors, into a "culture of safety" that focuses on openness and information-sharing to improve health care and prevent adverse outcomes. The AMA also supports the IOM's focus on the need for a system-wide approach to eliminating adverse outcomes and improving safety and quality, instead of focusing on individual components of the health system in an isolated or punitive way.

Toward this end, the AMA supports H.R. 663, the "Patient Safety and Quality Improvement Act," which was favorably reported by the House Energy & Commerce Committee on February 12, 2003. H.R. 663 would provide a framework to create a "culture of safety" by establishing a confidential, non-punitive, and evidence-based system for reporting health care errors. There is a very broad and strong consensus of agreement on this legislative approach within the health care community. By implementing this approach, errors can be identified and analyzed to improve patient safety by preventing future errors.

In addition to patient safety and quality improvement, the fear of litigation stifles the advancement of new medical treatments and medications, encourages physicians to practice defensive medicine, overwhelms the health care system with paperwork—leaving less time for patient care, and discourages qualified candidates from pursuing a career in medicine or from moving to a state with a bad liability climate.

## THE PRACTICAL SOLUTION

The AMA recognizes that injuries due to negligence do occur in a small percentage of health care interactions, and that they can be as devastating or worse to patients and their families than injury due to natural illness or unpreventable accident. When injuries occur and are caused by a breach in the standard of care, the AMA believes that patients are entitled to prompt and fair compensation.

This compensation should include, first and foremost, full payment of all out-of-pocket "economic" losses. The AMA also believes that patients should receive rea-

sonable compensation for intangible “non-economic” losses such as pain and suffering and, where appropriate, the right to pursue punitive damages.

Unfortunately, our medical liability litigation system is neither fair nor cost effective in making a patient whole. Transformed by high-stakes financial incentives, it has become an increasingly irrational “lottery” driven by open-ended non-economic damage awards. As mentioned above, studies show that our tort system, in general, is an extremely inefficient mechanism for compensating claimants—returning less than 45 cents on the dollar to claimants and only 20 cents of tort cost dollars to compensate for actual economic losses.

To ensure that all patients who have been injured through negligence are fairly compensated, the AMA believes that Congress must pass fair and reasonable reforms to our medical liability litigation system that have proven effective. Toward this end, **we strongly urge Congress to pass the “Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act,”** a *bipartisan* bill that would bring balance to our medical liability litigation system.

The major provisions of the HEALTH Act would benefit patients by:

- Awarding injured patients *unlimited* economic damages (e.g., past and future medical expenses, loss of past and future earnings, cost of domestic services, etc.);
- Awarding injured patients non-economic damages up to \$250,000 (e.g., pain and suffering, mental anguish, physical impairment, etc.), with states being given the flexibility to establish or maintain their own laws on damage awards, whether higher or lower than those provided for in this bill;
- Awarding injured patients punitive damages up to \$250,000 or up to two times economic damages, whichever is *greater*;
- Establishing a “fair share” rule that allocates damage awards fairly and in proportion to a party’s degree of fault; and
- Establishing a sliding-scale for attorneys’ contingent fees, therefore maximizing the recovery for patients.

These reforms are not part of some untested theory—they work. The major provisions of the HEALTH Act are based on the successful California law known as MICRA (Medical Injury Compensation Reform Act of 1975). MICRA reforms have been proven to stabilize the medical liability insurance market in California—increasing patient access to care and saving more than \$1 billion per year in liability premiums—and have reduced the time it takes to settle a claim by 33 percent. MICRA is also saving California from the current medical liability insurance crisis brewing in many states that do not have similar reforms. In fact, according to MLM, as discussed above, the gap between medical liability insurance rates in California and those in the largest states that do not limit non-economic awards is substantial and growing.

MICRA-type reforms are effective, especially at controlling non-economic damages. Several economic studies substantiate this point. One study looked at several types of reforms and concluded that capping non-economic damages reduced premiums for general surgeons by 13% in the year following enactment, and by 34% over the long term. Similar results were shown for premiums paid by general practitioners and OB/GYNs. It was also shown that caps on non-economic damages decrease claims severity (i.e., amount of the claim) (Zuckerman et al. 1990).

Another study published in the *Journal of Health Politics, Policy and Law* concluded that caps on non-economic damages reduced insurer payouts by 31%. Caps on total damages reduced payouts by 38% (Sloan, et al. 1989). Another study concluded that states adopting direct reforms experienced reductions in hospital expenditures of 5% to 9% within three to five years. If these figures are extrapolated to all medical spending, a \$50 billion reduction in national health spending could be achieved through such reforms (Kessler and McClellan, *Quarterly Journal of Economics*, 1997).

Further, as discussed above, a 2002 Congressional Budget Office study on H.R. 4600 (107th Congress) asserts caps on non-economic damages have been *extremely effective in reducing the severity of claims and medical liability premiums*. Conversely, a 1996 American Academy of Actuaries study shows that *medical liability costs rose sharply* in Ohio after the Ohio Supreme Court overturned a liability reform law in the 1990s that set limits on non-economic damages. (Ohio recently enacted a new liability reform law.)

Furthermore, a Gallup poll released on February 5, 2003, show that 72% of those polled favor a limit on the amount patients can be awarded for pain and suffering. This Gallup poll is consistent with a 2002 survey conducted by Wirthlin Worldwide showing that three-quarters of Americans understand the detrimental effect that excess litigation has on our health care system. The Wirthlin survey shows that the vast majority of Americans agree we need common sense medical liability reform.

In addition to the 78 percent discussed above who said that they are concerned about access to care, the survey found that:

- 71 percent of Americans agree that a main reason health care costs are rising is because of medical liability lawsuits.
- 73 percent support reasonable limits on awards for “pain and suffering” in medical liability lawsuits.
- More than 76 percent favor a law limiting the percentage of contingent fees paid by the patient.

#### CONCLUSION

Physicians and patients across the country realize more and more every day that the current medical liability situation is unacceptable. Unless the hemorrhaging costs of the current medical liability system are addressed at a national level, patients will continue to face an erosion in access to care because their physicians can no longer find or afford liability insurance. The reasonable reforms of the HEALTH Act have brought stability in those states that have enacted similar reforms.

By enacting meaningful medical liability reforms, Congress has the opportunity to increase access to medical services, eliminate much of the need for medical treatment motivated primarily as a precaution against lawsuits, improve the patient-physician relationship, help prevent avoidable patient injury, and curb the single most wasteful use of precious health care dollars—the costs, both financial and emotional, of health care liability litigation. The modest proposals in the HEALTH Act answer these issues head on and would strengthen our health care system.

The AMA appreciates the opportunity to testify on the adverse effect that our current medical liability litigation system imposes on patient access to health care and urges Congress to pass H.R. 5, the HEALTH Act.

Mr. BILIRAKIS. Thank you very much, sir.

A number of the members up here have 8 minutes for their inquiries, and we will remind you of that. I will just go ahead and start the questioning.

Mr. Rosenfield, and not that this question is not maybe appropriate to all of the others too, but I—late in the fall, I was invited to attend a large gathering, I will call it a seminar, if you will, because that is really what it turned out to be. Of an awful lot of medical providers in my part of Florida where they had, and my part of Florida is the Tampa Bay area, where they had, I guess, he is an attorney from Miami, come up and others, to advise doctors on how to go bare, b-a-r-e, I guess, that bare, advise them how to get rid of their assets and protect their assets and whatnot, and just go bare, without any insurance at all.

Now, it has been stated by at least one or two of you, didn't have to be stated, that we are taking away, in effect, constitutional rights of some of the—a patient, of Ms. Lewinski, and others, to be able to get a proper remedy, et cetera. But I would ask you, if a doctor has gone bare, and more and more are going that way, now you are talking about, I mean, if you are talking about a proper remedy, we are talking about no assets. And is that not more injurious to the patient than, let's say, a cap would be where there is insurance there, there is coverage and there is insurance, and certainly, the economic damages would be covered, would be picked up?

Mr. ROSENFIELD. Mr. Chairman, that is seriously injurious. But the premise of your question is that it is an inescapable reality. I think the experience in California under proposition 103 with stringent regulation is that you can force insurance companies to reduce their rates. And I think the message you are hearing from the—and we heard in Langhorne in the subcommittee hearing was that before the Congress, the 108th Congress moves to limit how much

victims of medical malpractice can receive, we ought to, it ought to investigate what is really going on with the insurance industry.

Because of the vast and overwhelming majority of evidence, even from the insurance industry, and I have included some of it in my written testimony, and I have an exhibit, with your permission, I would like to make part of the record. Even the insurance industry itself acknowledges that there is a cycle that occurs. And we have had three of them in the last 30 years, when we run into trouble in the market, when insurance companies' interest rates are lower and their investment income is reduced and the stock market goes bad, which this is a double whammy for them this time around.

When all of those things happen, the insurance companies run into trouble. The investigation should be into whether there is away to lower insurance premiums. And if the private insurance companies do not wish to sell insurance to doctors, the Congress could do many things to make it more—I am sorry.

Mr. BILIRAKIS. Well, forgive me. But I didn't want you to take up my entire 5 minutes.

Mr. ROSENFELD. I am sorry.

Mr. BILIRAKIS. You pretty well, I guess, answered my question.

Mr. Hurley, do you agree with the gentleman?

Mr. HURLEY. Agree in the sense that it is caused by investment losses and things like that?

Mr. BILIRAKIS. Well, certainly he made that comment here toward the end.

Mr. HURLEY. No, I do not agree that this investment losses cause companies to increase rates. As I mentioned in my testimony, rates are developed in a forward looking fashion. They do not depend on or look back at and recoup past investment loses. They do not recoup past inadequate rates. They are made based on projections of expected losses and expected future rates of return, not past rates of return or losses.

Mr. BILIRAKIS. Well, you seem to be awfully positive. Mr. Rosenfield seems to be awfully positive, and yet you disagree and we are supposed to leaf through all that and come up with what—Mr. Smarr. Comment? You are certainly, you certainly disagreed on proposition 103 and its effect.

Mr. SMARR. I indeed do disagree with that. Medical malpractice insurers were not the intended target of proposition 103. It was an automobile insurance initiative. Nevertheless, prop 103 did cover them. Prop 103 was passed in, I guess, 1988 and the insurance industry was very opposed to prop 103. In fact, insurance companies were still negotiating with the commissioner into the mid 1990's as to how they were going to fulfill the requirements of prop 103. The very first insurance company that did come to an accord with the insurance commissioner was the Norcal Mutual Insurance Company, one of my physician-owned malpractice insurance companies. And Norcal, in its agreements with prop 103—now prop 103 required the rollback of rates to 20 percent below those in effect in some date in November 1987. It did not require the refund of any money if you read prop 103.

But Norcal reached an agreement with the insurance commissioner that it would refund 20 percent of premium for 1 year to its doctors and that would be the entire commitment they had under

prop 103. And this was a sizable amount of money. And I have the consent order signed by Norcal and two other of my member companies here, which I would like to have entered into the record where they did.

Mr. BILIRAKIS. Without objection.

[The information referred to follows:]

Mr. SMARR. Norcal, at the time, showing the exhibit before you now, was paying dividends in each of the years during the prop 103 issue in excess of 20 percent. And so Norcal was able to fulfill its obligation to refund 20 percent through the normal dividend process. And that is also stipulated in paragraph 4 of Norcal's consent order. And thus, Norcal did not pay out any more money than it otherwise would have paid because of prop 103, and it clearly did not roll back its rates. And I have talked to my other California member companies, and I have been told the same story.

Mr. BILIRAKIS. Thank you, sir. My time is expired.

Ms. DeGette for 5 minutes.

Ms. DEGETTE. Thank you, Mr. Chairman. Well, just following up, it is correct, isn't it, Mr. Smarr, that the vast majority of States require physicians to have malpractice insurance so the vast majority of physicians would not be able to go bare, correct?

Mr. SMARR. I believe that is true.

Ms. DEGETTE. Thank you.

Ms. Lewinski, I want to thank you for coming today. We all sit around and talk about actuarial issues and this and that. But we really heard the human face, and I know your mom tells you this because I am a mom, too. But let me tell you and you might listen to it from me, you will find a boyfriend because you are so pure of heart and so articulate and someone's going to love you very much. So I just want to tell you that. And I know we all appreciate you being here. I just want to ask you two questions. First of all, when you—when you had this terrible injury by your doctor, you were 8 years old, right.

Ms. LEWINSKI. Right.

Ms. DEGETTE. And so the jury did not give you any award of economic damages, correct?

Ms. LEWINSKI. That is correct.

Ms. DEGETTE. Mr. Chairman, I would just like the record to reflect that if this legislation passed, Ms. Lewinski, despite everything that happened to her, would be entitled to an award of zero. Now, I have a couple of more questions.

Mr. Hurley, I listened very carefully to your testimony today and the upshot is, for a variety of reasons, you have no idea, really, how passage of this bill would affect malpractice insurance rates for doctors, do you?

Mr. HURLEY. I have not made any projection about what the impact of that bill would be no.

Ms. DEGETTE. Right. So you don't really know what, if any, effect this bill would have on these doctors' insurance rates, right?

Mr. HURLEY. I have not projected to answer your question, I have not made a projection on what the effect would be in terms of the impact on rate level. I think it is safe to say that over the long term, a bill of this nature would, in fact, stabilize price increases because it will stabilize increases and losses over the long term.

Ms. DEGETTE. Thank you.

Now, Mr. Smarr, I also want to ask you, you don't really have any idea, if premiums will go down, if Congress passes this law either, do you?

Mr. SMARR. I do believe that if Congress passes this law, and it stands constitutional muster, that rates will be reduced.

Ms. DEGETTE. Do you have data to support that contention, sir?

Mr. SMARR. The data that I have is that produced by the Congressional Budget Office and by the GAO, which looked at this issue.

Ms. DEGETTE. Okay.

Mr. SMARR. Pardon me. I misspoke. It is the Department of Health and Human Services, not the GAO.

Ms. DEGETTE. Okay. Mr. Smarr and Mr. Rosenfield, I would like to have you take a look at Exhibit 2-A. I am sorry. Yeah. 2-A and 2-B, it is this chart right here. It should be on the back screen, if we could have someone put it up. It is labeled "premiums and damage caps for top 26 States." 2-B is for bottom 27 States. I don't know if you have that in front of you or not. There it is, behind you. Now, take a look at the top five States in terms of premium, Florida, Michigan, Nevada, Ohio, West Virginia. Do you see that?

Mr. SMARR. Yes.

Ms. DEGETTE. Now, in all of those states they have caps, correct, Mr. Smarr? Yes or no?

Mr. SMARR. No, I don't agree with that.

Ms. DEGETTE. You don't agree that they have caps? Mr. Rosenfield, do you believe they have caps in those five States, Mr. Rosenfield?

Mr. ROSENFELD. Yes, I do believe that. I will double-check, but I believe it.

Ms. DEGETTE. Okay. Now, if you take a look, but yet, what I am looking at, those are the five States that have the highest premiums in the country, but they also have caps, correct, Mr. Rosenfield?

Mr. ROSENFELD. You know, I can't—this is not our chart. I have been to those States. They have caps. I can't tell you what the amounts are.

Ms. DEGETTE. What the premium is?

Mr. ROSENFELD. Yeah. I can't tell you.

Ms. DEGETTE. Okay. Take a look at now Exhibit 2-B, if you will. Take a look at the bottom, at least the bottom State, Oklahoma, they have the lowest premiums and they also have no cap; is that correct, Mr. Rosenfield?

Mr. ROSENFELD. That is what that chart says.

Ms. DEGETTE. Do you know if that's true or not?

Mr. ROSENFELD. It is not my chart. No, sorry.

Ms. DEGETTE. Mr. Smarr, do you know if that is true?

Mr. SMARR. I have no idea.

Ms. DEGETTE. Do you have any reason to disagree with that?

Mr. SMARR. I can't comment on the chart because I don't know where the data comes from.

Ms. DEGETTE. The data comes from Medical Liability Monitor. Are you familiar with that publication?

Mr. SMARR. I am very aware of that publication.

Ms. DEGETTE. Is that a legitimate publication?

Mr. SMARR. Yes, it is.

Ms. DEGETTE. Would you have any reason to disagree with this data?



Mr. SMARR. I might, because I don't know how the data was extracted from the publication.

Ms. DEGETTE. Okay. So you think that in Oklahoma they might have a cap. Do you disagree with these charts which indicate that the States with the highest premiums also have caps and the States with the lowest premiums either have very high caps or no caps whatsoever?

Mr. SMARR. Congresswoman DeGette, I can't agree with anything on that chart because I do not know how it was derived.

Ms. DEGETTE. Do you agree with the concept?

Mr. SMARR. The concept?

Ms. DEGETTE. Yeah.

Mr. SMARR. Yeah.

Ms. DEGETTE. Thank you.

Mr. BILIRAKIS. Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman. It is difficult for us to reach a consensus on how to solve the problem since we can't, haven't reached anything like a consensus on what causes the problem. And the opponents of this legislation seem convinced that the cause of the problem has to do with either bad investments by insurance companies, or price gouging. That seems to be the mantra that is repeated over and over again.

Mr. Hurley, I know you have been asked this before, but looking at the chart there, we see a number of States, California, Colorado, New Mexico, Indiana, Wisconsin and Louisiana, that don't seem to be in crisis right now. Mr. Rosenfield believes that he is the hero in California, that the reason they don't have a problem is because of his efforts. That is disputed by others. But Mr. Rosenfield didn't pass propositions in those other States, so do you have any—can you offer us any wisdom or why there would be such variation among the States, even though you have said that you do not believe that investments, bad investments are the causal factors of these malpractice increases? Can you give us some wisdom as to why there is a variation in States?

Mr. HURLEY. Congressman, I will try. I think that to reiterate, it is not investments that is driving the prices. The prices are driven by losses. The losses are driven by the frequency and severity of claims in each jurisdiction and each jurisdiction has its own set of rules as to what happens in that jurisdiction in terms of filing a claim many so it is the frequency and severity of claims, that is affected by the rules that operate in each of those several States. And just to touch on the issue of prop 103, any form of regulation that is in place is not going to stop a company from going broke. If the losses are bad, companies will seek increased rates. If a regulation stops them from getting those increased rates commensurate with the losses they will go broke. The fact of the matter is that the losses didn't increase enough to cause companies to file rates in California that require them to get higher rates and therefore—

Mr. GREENWOOD. Okay. Let me stop you in the interest of time. So what we know is all of the—the stock market applied to all of those 50 States, even if it were, even if you tried to make the arguments that this is all about stupid investments, or not even stupid investments, but loss in the stock market, you would have the dif-

ficulty, I think, you would have a difficult time, I think, explaining why some States are insurance companies that provide insurance, liability insurance in the white States there, somehow had a different investment history than the States, than the companies providing insurance in the red States. That is nonsensical.

But you are saying it doesn't have anything to do with investments. It has everything to do with losses, and losses are a function of State law and an important function of State law is caps. And it so happens that the one thing that those white States all have in common is they all have caps.

Now, let me turn to Mr. Smarr. Mr. Smarr, I said in my opening statement that I had a hard time believing that this was, I would be delighted to solve this problem if we could figure, if we could lay the blame at the fault of the insurers and do something to fix that. That would be great with me. I just want to make health care available in my State. But you represent the physician-owned insurance companies, and would it be fair to say that the physician-owned insurance companies fundamentally exist for the purpose of trying to provide physicians with the lowest possible and most affordable medical liability premiums?

Mr. SMARR. Yes, sir, it would. The companies were formed back in the late 1970's, specifically for that purpose to provide a market for doctors and hospitals and dentists and to be able to ascertain the two true crosses of medical liability insurance, because nobody believed the commercial carriers at that time that things were as bad as they were.

Mr. GREENWOOD. Right. So you had to get away from those big bad private insurers which might have been price gouging, and let the physicians go about it themselves. Have you been able to significantly offer rates to your physicians, these companies that you represent, at a different, a significantly different rate than the private sector has.

Mr. SMARR. No.

Mr. GREENWOOD. Why is that?

Mr. SMARR. Because the costs were real.

Mr. GREENWOOD. The costs were real. So it is not that, even with all of their alleged price gouging and overpricing and all of their stupid investments and all of the rest, you are out there trying to find—to make investments that make sense. And I think it is only 15 percent of all insurance companies, I think, have—medical liability insurance companies invest in the stocks, isn't that what you said, Mr. Hurley?

Mr. HURLEY. It is approximately.

Mr. GREENWOOD. It is only 15 percent in stocks to begin with. Okay. But you are out there, your companies, who provide insurance for 60 percent of the doctors in the country; is that right?

Mr. SMARR. That's what we estimate yes?

Mr. GREENWOOD. So you are out there trying your level best to be as conservative with your investments, to be as conservative with your premiums, and you are still not able to significantly, if at all, offer a product at a lower price than any of the private sector; correct?

Mr. SMARR. Essentially correct, yes.

Mr. GREENWOOD. Okay. Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Brown, 5 minutes.

Mr. BROWN. Thank you Mr. Chairman. I have a couple of quick questions.

Dr. Palmisano, you are a physician. Do you believe a \$250,000 cap for all victims of malpractice is sufficient, no matter how severe the injury?

Mr. PALMISANO. The American Medical Association's policy is the MICRA legislation. That has been the policy for a number of years. And this past year, the American Medical Association voted to make medical liability reform its No. 1 legislative—

Mr. BROWN. Is that a yes?

Mr. PALMISANO. [continuing] priority.

Mr. BROWN. Could you give me a yes or no on that?

Mr. PALMISANO. Well, we believe you have to have a balance.

Mr. BROWN. Would you give me a yes or no? Do you think \$250,000—I mean, you have got a policy. I don't want it explained. If you—

Mr. PALMISANO. I just want you to understand, it is the American Medical Association's policy. I am not giving my personal opinion here.

Mr. BROWN. Well, the American Medical Association thinks \$250,000, regardless of the severity of the damage, is sufficient.

Mr. PALMISANO. For noneconomic damages, in order to balance and be sure we have access to care for all of the patients.

Mr. BROWN. No, I don't need the editorial comment. I only have 5 minutes.

Mr. PALMISANO. I am giving you the background.

Mr. BROWN. I appreciate that. Thank you, Dr. Palmisano. Mr. Smarr—I apologize for cutting you off like that. I just have several things I want answered. Studies show that only one in seven victims of malpractice ever file a claim. Is that too many? One out of seven?

Mr. SMARR. Is that too many?

Mr. BROWN. Yeah.

Mr. SMARR. No.

Mr. BROWN. Okay. What percentage of victims—what percentage of victims are entitled to compensation? If only one out of seven files.

Mr. SMARR. Well, I personally believe that any victim is entitled to be made whole.

Mr. BROWN. Made whole. Do you think a \$250,000 cap is adequate always in every case?

Mr. SMARR. I believe that a \$250,000 cap is an equitable standard, yes, I do.

Mr. BROWN. In every case?

Mr. SMARR. Yes.

Mr. BROWN. Okay. That's interesting. Okay. My friend, Ms. Rosenbaum, my friend Mr. Greenwood, mentioned in his opening statement there is no reason to subpoena insurance industry records, because he said because 60 percent of medical malpractice insurance is provided by physician-owned companies. The goal of a subpoena is, however, to gather information so we can justify the kind of sweeping change that this legislation offers.

Would you tell us what information we should want, we should need from insurance companies, the information that we can't, we seem to not be able to get, short of a subpoena? And the majority party won't allow a subpoena for whatever reason. They don't want us to know more about the inside workings of the insurance industry. Should we have to—what should we want, data on investment practices? Payroll of the executives? Amount in the reserves pay out on claims? What kind of information should we want?

Ms. ROSENBAUM. I think what you need to focus on, particularly are any internal studies that breakdown the relative magnitude of the various components of payouts. For example, there are studies that suggest that by far, in many cases, the highest part of the payout is the economic damage, that, in fact, non-economic damages are relatively modest. And that is because of the length of life of certain injured persons, the complexity of the treatment.

So I would want to know a great deal about exactly what a claim breaks down into. I would also want to know, I think, the extent to which there are internal memos and studies that identify the losses that a company experiences that are attributable to a shortfall in the premium-paid increases to the payout, versus the kinds of underlying shortfalls that simply come because of the way in which revenues are managed. This is true for any complex corporations; it is true for my own university, where our dilemma right now is not the tuition payments are too low, it is that the return on our endowment is too low.

And that drives tuition payments. And I assume that it is the same kind of complicated issue for any corporation—public, private, nonprofit, for profit. So it is that—it is the underlying cause of the escalation that you would have to get at.

Mr. BROWN. Thank you for that.

Mr. Rosenfield, you seemed, when Mr. Smarr was talking about Prop 103—not to try to read into your facial expression, but you seemed not to agree with that. But could you—we don't have a lot of time, but talk about briefly why you think 103 brought down rates and why MICRA didn't seem to? Briefly.

Mr. ROSENFELD. Well, it is not my thinking. That exhibit 1 shows that premiums soared 571 percent until Prop 103 passed, and then they went down 20 percent. It is that insurance industry data. And the reason why is because—nothing inherent in tort reform—it does stop insurance companies from boosting premiums. There is no requirement that they not. And so when Proposition 103's regulatory structure took effect, it forced the insurance companies to reduce premiums for a one-time rollback and refund.

But then if you look at the other charts in the testimony, you will see that unlike the other States, where these wild gyrations—that is caused by the insurance industry cycle; that is actually documented by the medical insurer itself in my exhibit here, unlike other States because Prop 103 does not allow unjustified decreases, ill-advised decreases. So in California, 103 has eliminated the instability of the insurance cycle. That is a value too.

Mr. BILIRAKIS. Mr. Deal for 8 minutes.

Mr. DEAL. Thank you, Mr. Chairman.

I think all of you have provided very valuable insight. I want to question some of your statements and see if I can make some sense

out of it even further. Obviously one of our purposes here is to do something that is going to be effective, and one of the things that I think would be effective is to determine if several things will happen with H.R. 5 passing.

One would be, are we going to see a decrease in malpractice premiums?

Now, I think from hearing the testimony and reading the material here, I don't see that happening. Mr. Smarr, I am looking at your testimony on page 14, and you list the causes of the crisis, and it appears that only the latter one maybe is directly related to what we are doing here and that is a greater proportion of large losses. And you say the primary driver of the deterioration in the medical liability insurance industry performance has been paid-claim severity.

You go on to point out in your letter to Senator Gregg that the preliminary evidence points to a rising loss cost and defense cost associated with litigation as the principal drivers of medical malpractice prices.

So, are we going to see a decrease in medical malpractice cost if H.R. 5 passes?

Mr. SMARR. Yes, sir, I believe we will. And I believe that the experience in States that have effective tort reforms speaks to this.

The Congressional Budget Office, in scoring H.R. 4600, stated that if that bill, which is essentially identical to H.R. 5, were to become law, medical malpractice rates would be—I believe it is 25 to 30 percent lower than they would otherwise be had the legislation not been adopted.

Mr. DEAL. That seems to fly in the face of the testimony that Mr. Rosenfield had submitted as to what happened in the State of Florida, which immediately after their legislation was put in place, two of the larger ones immediately asked for rate increases and indicated that their reforms had no relationship to the cost of malpractice coverage.

How do you distinguish that?

Mr. SMARR. If you are referring to the cap on noneconomic damages that is in place in Florida, I can't remember if it is a \$250-cap or a \$500,000 cap, that cap only applies in cases where the issue is settled through arbitration; and that rarely happens because both sides have to agree to arbitration. So the cap in effect is not in effect.

Mr. DEAL. Okay. We have some very qualified people on this panel. I am going to ask you about the portions of this bill that, in my opinion, should relate to overall cost and their relation to the marketplace. I am going to ask if any of you have any studies to indicate if any of these have individually been scored as having an effect on premiums or availability, the cap on noneconomic damages.

Does anybody have any statistics to show what effect, if any, that has on rates or availability of coverage? What about statute of limitations?

Excuse me. Go ahead.

Mr. SMARR. Yes, sir. The Congressional Budget Office did indeed score that.

Mr. DEAL. Did they score that element alone as having a cost factor associated with it?

Mr. SMARR. I believe that is cited as being the primary driver, yes, sir, but I would have to go read the scoring analysis.

Mr. DEAL. So by capping the pain and suffering area, that has an effect on the ratio, on the availability and the cost of liability insurance?

Mr. SMARR. Yes, sir.

Mr. DEAL. Statute of limitations change? Anybody have anything associated with that? The apportionment of damages, anybody have any information indicating that makes a difference?

Mr. HURLEY. May I add something? I think there have been studies done of these things. I have not personally done those studies, but I think a couple of references have been made to studies that did look into some of these elements. They would have been done, for example, by the Office of Technology Assessment back in the earlier part of the decade, in those types of timeframes.

There have been other academic studies done by RAND and others that looked at some of those. Those might be helpful to access.

Mr. DEAL. Would that be true of the apportionment of damages provision, the collateral source rule, the periodic payments?

Mr. HURLEY. I think most of those elements have been addressed.

Mr. DEAL. If any of you have that material, I think it would be helpful if you could get that to us at a later time.

Let me tell you about one of the things that concerns me. And, Mr. Smarr, I have taken your statistics on chart 14, and I think all of us are concerned that we deal with this issue fairly.

Based on your mean indemnity payment of \$310,215, if I calculated out using the limit on collateral fees for the plaintiff's attorney, let's assume you won that case at your average \$310,000. As I calculate it out, he will be paid \$78,198 out of that award.

Now, if I look at what you are paying your attorneys to defend that case, they lost the case, they are paid \$91,423. In other words, the winning plaintiff's lawyer gets only 85 percent of the amount that the losing defense attorney gets. And if you have to reduce what the winning plaintiff's attorney gets from the award being received by the injured plaintiff, you reduce that award down to the point that your losing attorney is going to be paid 40 percent of the amount that the winning plaintiff, the individual injured party, is actually receiving.

Now, how do we reconcile that?

Mr. SMARR. Congressman Deal I didn't follow the first part of your calculation when you came up with the \$78,000.

Mr. DEAL. Well, I have taken the contingent fee schedule on your average award of 310,000-plus. A winning attorney who gets that award is going to receive a little over \$78,000; your losing attorney, by your statistics, is going to be paid in excess of \$91,000.

What I am saying is—well, my bottom line, I guess, is, would you favor a situation in which the loser pay prevails? Or would you consider it fair that if we are going to disclose collateral sources, where some of these expenses may have been paid, the jury be told that the plaintiff's attorney is going to get a certain percentage of the award or anything along those lines?

You know, I think there is a basic element of feeling that the person who is the injured party here and their attorney are having to take the risk in filing the suit. I know you win most of the cases, I know you do; but if we are going to reveal collateral source, shouldn't the jury also know in this average award that 25 percent of it is going to go to the plaintiff's attorney and that they are not allowed to award the winning party that 25 percent? Is that fair?

Mr. SMARR. Award the winning party 25 percent?

Mr. DEAL. Yes. Yes. They are not allowed to consider an award for the plaintiff's attorney who wins the case, are they?

Mr. SMARR. Well, the plaintiff's attorney who wins the case gets the contingency fee, which is far in excess of 25 percent, as I understand it.

Mr. DEAL. Not according to what the law calls for that we are looking at. But he has to take that out of his plaintiff's award.

Mr. SMARR. That is true. That is the way the system works.

Mr. DEAL. Well, would you be amenable to the jury knowing that?

Mr. SMARR. My organization does not have a policy on that, and——

Mr. DEAL. Because your defendant's attorney is going to get paid anyway, aren't they, whether they win or lose?

Mr. SMARR. That is true.

Mr. DEAL. In fact, according to your chart, get paid a little more to lose than they do to win.

Can you give us an idea what the average per hour rate is that your companies are having to pay for defense attorneys?

Mr. SMARR. These costs are not, by the way, just attorneys' fees. About 75 percent of the costs are attorney fees, but they are also expert witnesses and court costs that are included.

Mr. DEAL. Expert witness fees are usually other doctors that are being paid to come testify.

Mr. SMARR. Usually other doctors; that is right.

Mr. DEAL. Can you give us an idea what the average per hour rate is being paid for the defense of these cases?

Mr. SMARR. I do not know an average because we have not computed one, but lawyers usually make \$150, \$200 an hour, \$250 an hour.

Mr. DEAL. In this area, they get paid substantially more as a general rule, wouldn't you think?

Mr. SMARR. In malpractice work, my own personal experience in trying to control these costs is that the companies do a pretty good job of riding herd on the defense attorneys and keeping their fees down. The attorneys do a good bit of business with the malpractice companies, so they have some leverage over the defense attorneys so the fees are not as high as if you went downtown and hired a——

Mr. DEAL. Less you misunderstand my position, I do support the legislation. I just think there are some hard questions that we have to answer, and I think if you can help us answer those, we need to answer those.

Mr. BILIRAKIS. The gentleman's time has expired. I apologize, Mr. Smarr.

Mr. Waxman for 5 minutes.

Mr. WAXMAN. Thank you very much, Mr. Chairman.

I believe medical malpractice is a serious problem, but I am amazed when my Republican colleagues want to take issues like health care for these seniors and the poor in our society and shift all that over to the State or important national environmental standards and say, we will let the States deal with it. Suddenly they don't think the States are capable of dealing with the medical malpractice issue even though it is the States that license the doctors and health care professionals, the States that regulate the insurance industry, and the States that discipline medical professionals if they don't do their job adequately.

I was involved with—as Mr. Hiestand pointed out in his testimony, the California proposal prior to when it was adopted when I was in the State legislature. But California adopted a proposal that I didn't fully agree with because I don't like the idea of arbitrary limits on recoveries for pain and suffering. But California did what it did; other States can do what they think is appropriate.

I think we ought to let the States operate in this area and not have the Federal Government take it over. I don't think Washington knows the best for everybody in the country, and I think States ought to deal with this matter. But the whole purpose of medical malpractice lawsuits is twofold: one, to make the injured person as a result of medical malpractice whole, to compensate them for their loss; and second, to deter doctors and other medical professionals from committing medical malpractice.

If you are going to make someone whole who has been injured, you ought not to put a limit, an arbitrary limit, on what they can recover. Heather Lewinski is here and testified from her own experience. To just say there ought to be an arbitrary limit of \$250,000 for all the pain and suffering you have gone through—in how many operations was it, 13—

Ms. LEWINSKI. 14.

Mr. WAXMAN. [continuing] 14 separate operations from a doctor that didn't know what he was doing, committed clear malpractice; and to say that you were going to be compensated by an arbitrary amount for the rest of your life, how does that make you feel? Would you feel that you were compensated fully if you were given that limit?

Ms. LEWINSKI. Absolutely not.

Mr. WAXMAN. I think it is so unfair not to look at each individual case and then decide what is the right compensation for that individual.

Now, California has a law that appears to be successful; at least some people think it is very successful. But California does a lot of things that MICRA doesn't do. As I understand it, California regulates insurance a lot more than if this bill were adopted at the Federal level.

Is that right, Mr. Rosenfield?

Mr. ROSENFELD. Yes, sir.

Mr. WAXMAN. So I don't know if the Republicans are going to say we ought to regulate insurance at the Federal level. I doubt it. They have been pretty accommodating to the insurance industry as long as I have been in the Congress of the United States.



So it is troubling to me to hear this notion that Washington knows best, one size fits all, that we can take away from the States the responsibility to figure out what is best for their own people, and then put some limit that is arbitrary on what somebody could recover when they are injured.

Now, whatever the figure someone had about the number of people that are injured from medical malpractice that never get any recovery, never even get into court—do you know that figure, Mr. Rosenfield?

Mr. ROSENFELD. I think it is only one out of every eight injured victims actually filing a lawsuit.

Mr. WAXMAN. Why is that?

Mr. ROSENFELD. Maybe the nature and extent of the injury, maybe that they are not sufficiently represented. In California, it is certainly because MICRA alters the cost-benefit ratio to make it impossible for an attorney to take all but the most egregious cases involving all but the most wealthy people.

Mr. WAXMAN. Well, the idea of a limit on pain and suffering was to—somebody said, to balance it out. But the real purpose then is not only not to compensate the person adequately, but to keep them from being able to get a lawyer?

Mr. ROSENFELD. The undeniable impact of California of MICRA—and this has been and acknowledged by the insurance industry's top defense counsel who spoke before Congress on this point—is that it has deterred legitimate cases from getting into the courthouse.

Mr. WAXMAN. Let me ask another Californian, Mr. Hiestand.

Do you believe that the limit on pain and suffering of 250,000, which has not been adjusted for inflation, keeps some people from ever getting a lawyer to represent them?

Mr. HIESTAND. Well, the statistics don't show that. The frequency, that is, the number of claims that have been failed for medical malpractice, given the growth of physicians and the growth of the population, has not changed in California both before MICRA and after MICRA. So the number of lawsuits with those adjustments would indicate that there has not been an inability for people to get doctors.

And the Federal experience——

Mr. WAXMAN. Get lawyers.

Mr. HIESTAND. The Federal experience——

Mr. WAXMAN. Do you believe that there are a lot of people who are not compensated, who are victims of medical malpractice because the system does not lend itself to hearing their problems?

Mr. HIESTAND. Well, people, as Mr. Rosenfield mentioned——

Mr. WAXMAN. Yes or no?

Mr. HIESTAND. Yes or no.

Yes. People with small injuries can't get lawyers in all kinds of contexts. And that happens in medical malpractice.

Mr. WAXMAN. I thank you all. My time has expired.

Mr. BILIRAKIS. Mr. Norwood for 5 minutes.

Mr. NORWOOD. Yes, sir. Thank you, Mr. Chairman.

Ms. Rosenbaum, I want to—I know that you have taken time to try to go through some of the definitions, which is a very hard thing to do. Not being a lawyer, it is very difficult for me to under-

stand when words don't mean anything; one person thinks a word means this and another person thinks a word means that, so sometimes it is not clear what actually the definitions are. And I think most of us appreciate your insight on this very difficult part of trying to understand H.R. 5.

You made a comment that I found interesting when you said that perhaps we have the focus on the wrong thing. And I don't want to go here particularly, but you said that maybe we ought to be really looking at economic damages rather than noneconomic damages; and I find that very interesting and would appreciate it if you would respond to the committee on that and give us your thoughts about that.

I don't want to go there because we don't have but 5 minutes, but I have been suspecting that was maybe part of the problem too.

Could you just simply answer for me, do you support any changes to the existing medical liability system?

Ms. ROSENBAUM. What I support is some intervention that would stabilize, control and not allow these rapid price swings in malpractice——

Mr. NORWOOD. Would you be good enough to respond to the committee your thoughts on what changes would be appropriate, in writing, so that we could have time to look at that?

I have some thoughts about H.R. 5 that I believe I am right on, and I want to go through some of those, if I may, with you. Get this chart put up, please. I would like to go through some of those and see if you disagree with me.

I don't believe H.R. 5 prevents an injured patient from recovering so-called "pain and suffering" or noneconomic damages. I don't believe this bill prevents that, do you?

Ms. ROSENBAUM. Well, there is a limit on noneconomic damages.

Mr. NORWOOD. I understand there is a limit, but there is not a prevention of recovery of whatever that limit is.

Ms. ROSENBAUM. My understanding is, it is a cap.

Mr. NORWOOD. I believe H.R. 5 simply establishes a minimum Federal standard of \$250,000 for noneconomic damages in States that have not already set a specific monetary amount on the size of noneconomic damage awards.

Do you agree with that?

Ms. ROSENBAUM. I do not. I think the preemption language only withholds preemption in those States whose limits are stricter.

Mr. NORWOOD. There are other attorneys who don't agree, obviously, the people—the lawyers who wrote up the bill; and somehow or another we have to figure that out. Perhaps—could you give us some information on that?

It is my understanding that the \$250,000 for noneconomic damages in States that already have set an amount—if the State of Georgia sets an amount of 350,000, that is the amount that is going to be in the State of Georgia, according to the results of this bill. And I believe that—help me if you don't. I believe H.R. 5 does not change existing straight caps on noneconomic damages, even though some of those may be higher than 350,000—and obviously they are, according to that chart behind us.

And you don't believe that to be true in this bill?

Ms. ROSENBAUM. Looking at section 11(b) of the bill, I do not.

Mr. NORWOOD. I am informed by another lawyer that the 11(c) part of the bill does allow for that. So again it is one of those areas where we have a very friendly disagreement.

I guess I believe the 11(c) part does. I believe H.R. 5 does not prevent a State from keeping or enacting an entirely different standard to guide the award of compensatory and/or punitive damages.

Do you think H.R. 5 doesn't do that?

Ms. ROSENBAUM. I am sorry. Would you repeat the question?

Mr. NORWOOD. H.R. 5 doesn't prevent a State from keeping or enacting a different standard to guide the award for compensatory and punitive damages. In other words, other States can have higher damages if those other States pass that in their State.

Ms. ROSENBAUM. I would have to look at 11(b) and (c) and respond to you in writing. And it would be of great help to me if this part of the record could be sent to me so that I will have your full question.

Mr. NORWOOD. I am trying to make sure what I believe about H.R. 5, that I am going to vote for, is in fact so and I believe it. But I don't mind giving you the opportunity to make me look another way.

Last, let me point out this chart behind us that was put up—Mr. Smarr and others, I think you were pretty wise not to pay attention to that because you look at the top five who have high caps, also high premiums, and one would think it would be implied that all those caps didn't work.

But I think we all ought to note that Nevada and Ohio and West Virginia—in fact, West Virginia just had a special session of their legislature and just put those caps in place. So to say those caps equate to those premiums is very misleading.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Dingell for 5 minutes.

Mr. DINGELL. Mr. Chairman, thank you. I would like to defer to Mrs. Capps, if I could.

Mr. BILIRAKIS. Well, Mr. Stupak would be first.

Mr. Stupak for 8 minutes.

Mr. STUPAK. Thank you, Mr. Chairman.

And thank you, Mr. Dingell.

Mr. Rosenfield, you indicated in your testimony that insurance companies are exempt from antitrust.

Should Congress repeal that and why?

Mr. ROSENFELD. Well, the voters repealed it in California because it is anticompetitive. And one of the problems with the industry has been that it circulates among insurers' data concerning losses, expenses, projections of future losses whether they materialize or not; and the circulation of this information is, by definition, anticompetitive since it allows all the other insurers to base their rates upon the same data.

Mr. STUPAK. So we heard testimony of a 400 percent increase, like that in California. If you are not subject to antitrust laws, you can set it wherever you want; isn't that correct?

Mr. ROSENFELD. That is correct. And it is very easy, because they circulate this insurance among themselves as insurers and ev-

everybody is aware of it, everybody knows what all their competitors are doing.

Mr. STUPAK. So if we are really concerned about lowering rates for malpractice, should we not take away that exemption for insurance companies and make a more competitive market to help drive down the cost of insurance?

Mr. ROSENFELD. That is what we did in California, and the impact not only on medical malpractice, but on auto insurance premiums was profound.

Mr. STUPAK. Well, we had that amendment, and actually it failed. So hopefully it will be part of this bill if it moves forward in this committee and onto the House floor.

Mr. Smarr, in your testimony, I was intrigued with your exhibit number 22 where you had the 2000 rates for L.A., Milwaukee, Chicago, Philadelphia, Miami. I come from Michigan, and we mirror Illinois quite a bit. Looking at it, Illinois doesn't have any caps, and Michigan does. In fact, our caps go back to, I believe, 1982. They were then increased again in—not increased, but more limitations were put on plaintiffs in 1994.

And in your chart here on exhibit number 22 you have for IM, which is internal medicine, \$26,000 paid in Chicago; GS, general surgery, \$68,000—these are in premiums—and then OB/GYN, \$102,000. And you have got, “as reported by the Medical Liability Monitor.”

Well, you know, I have got the Medical Liability Monitor here in front of me, a copy of it, and it is October of 2002, the same time; and when you take a look at internal medicine, it is \$19,000, this for State of Illinois—Michigan, it is \$26,000, again we have the caps.

On general surgery, it is only \$51,000, not the \$68,000 you report; Michigan it is \$71,000—again, Illinois no caps, Michigan has caps.

And your OB/GYN for Illinois—again, no caps—at \$79,000; Michigan, with the caps it has \$88,000.

Every one of your figures is one-third higher than what is reported. And we are both citing the same Medical Liability Monitor, which you said was credible, and you even cite it in your report. How do we get a third higher for these folks in your figures when I have the other figures from the magazine that are a third less?

Mr. SMARR. Well, Congressman, I am reading from the source document of the ISMIE mutual insurance company, which is the largest writer in the State; it is a company that is formed and operated by the State medical association.

Mr. STUPAK. So you are saying, you took only one medical malpractice provider and used their statistics, which were probably the highest in Illinois. You didn't take the average of all the underwriters in Illinois to get the average that an Illinois physician would pay?

Mr. SMARR. I took the leading writer in the State that had the largest market share.

Mr. STUPAK. And also the highest?

Mr. SMARR. No, I did not do it with that in mind.

Mr. STUPAK. Answer me this question. We will disagree on the premiums.

Why would Illinois—why would Michigan be higher, \$88,000 to \$79,000 for OB/GYN, 71 to 51 for general surgery, 26 to 19 for internal medicine—why would Michigan be higher, and we have all these caps? We have had them in place for over 20 years. Why would it be higher than Illinois that have no caps if caps are the panacea to our problem here.

Mr. SMARR. First of all, ProAssurance has higher rates in Illinois than does ISMIE. Michigan, I am told, has what is called a frequency problem in that the doctors in Michigan actually buy lower limits of insurance than in other places in the United States, and they get sued more often.

Mr. STUPAK. Wait a minute. They have got lower rates? But according to your monitor, Medical Liability Monitor, which you agree on, Michigan's premiums are actually higher than Illinois. You would think Illinois, then, would have these problems. We don't have any caps there in Illinois.

Mr. SMARR. Again, it is related to the tort environment and the area of Michigan.

Mr. STUPAK. Well, the tort environment, Illinois would be much more generous to a plaintiff because they have no caps; and Michigan has caps, so they would be less generous to a plaintiff, correct?

Mr. SMARR. Michigan's caps simply aren't working.

Mr. STUPAK. How can they not work? If our cap is \$280,000 in Michigan for noneconomic damages, how does an jury award more than \$280,000 and the judge not roll it back if that is the State law?

Mr. SMARR. I believe the caps are higher for serious injuries.

Mr. STUPAK. Oh, really?

Mr. SMARR. There are exceptions to the Michigan cap, yes, sir, there are.

Mr. STUPAK. The highest you can get in Michigan, like the loss of a child, is \$500,000. So how is that so much higher? I mean, in Illinois it is unlimited.

Mr. SMARR. Again, on a per doctor basis, if you will, there are more lawsuits. There is a frequency problem in the State of Michigan which is also driving rates in that State.

Mr. STUPAK. Do we have bad defense attorneys there or what?

Mr. SMARR. I don't know.

Mr. STUPAK. Let me ask you this one.

You know, you talk about your median. I want to go to your chart again; I think it is number 13 were you had almost like a half million dollars. You had, chart 13, median verdict is \$496,726. And in the National Practitioner Data Bank—are you familiar with that?

Mr. SMARR. I am.

Mr. STUPAK. Is that a credible organization?

Mr. SMARR. Yes, sir, it is.

Mr. STUPAK. They have got—I have got to read right here from the National Practitioner Data Bank—the median medical malpractice payout for 2000 is \$125,000 not \$496,000.

How do you reconcile that? It is four times, your numbers are four times higher.

Mr. SMARR. I can reconcile that, Congressman.

First of all, you are comparing a median with a mean. Second, you are comparing an average payment value for all payments with an average payment value for a verdict.

Mr. STUPAK. You agree with me, these numbers just don't jibe?

Mr. SMARR. They are apples and oranges.

Mr. STUPAK. Apples and oranges. Okay.

How about this one. You run an insurance company. Some professors at Duke University, for Indiana, State of Indiana, looked at the medical liability issue there. And we always hear this thing that insurers constantly must settle frivolous lawsuits in order to make them go away.

Do you settle frivolous lawsuits to make them go away, your company?

Mr. SMARR. I don't work for a company. I work for a trade association.

Mr. STUPAK. Your association that provides the insurance—

Mr. SMARR. The physician-owned companies are much more reticent to make what is called an economic settlement. And that is where it is cheaper to pay a small amount in indemnity than incur large amounts in defending a claim. It is part of the fabric of why the company has reformed.

There are some cases where it is—where it is done, such as there are changes in the records and things like that.

Mr. STUPAK. Let me read this statement, professors from Duke Law School, who did this for Indiana, when they were looking at their case, they said—here is what the insurers said, We don't settle frivolous cases. The insurers' policy on frivolous cases is based on the belief that if they begin to settle just to make them go away, their credibility will be destroyed and this will encourage more litigation. Is that true?

Mr. SMARR. I believe in that, yes, I do.

Mr. STUPAK. So you don't settle frivolous claims? The only cases settled are valid claims?

Mr. SMARR. By and large, that is true. There are exceptions.

Mr. STUPAK. I have got to stop now. I was just having fun.

Mr. BILIRAKIS. Let's see.

Mr. Shadegg for 8 minutes.

Mr. SHADEGG. Thank you, Mr. Chairman. I want to thank each of our witnesses for being here today. I think it is a very interesting discussion. As is often the case, I just come at this from a different perspective, perhaps, than anybody else. I am deeply troubled by the crisis we face in the tort system in medical malpractice right now, but I am also deeply troubled by the notion of hard dollar caps. I just can't get beyond the notion that that is government price fixing.

When Ms. Lewinski sits here and you think about the application of a government-set cap to her circumstance, it is a very, very difficult situation. I have supported this legislation in the past, and I may support it again, but I simply believe we are going in the wrong direction.

I want to follow up on some of the questioning that Mr. Stupak just asked. Is there anybody in this room that doesn't believe that, in fact, we are—that there are many claims in which settlement is paid at some cost higher than its merit to avoid the cost of defense?

That is, does anybody in this room believe that the ability of someone to bring a lawsuit in the United States and to know that since we do not have loser pay, there is no penalty, isn't used to extort settlements for some cases that lack merit?

Does everybody agree that that does, in fact, happen?

Mr. ROSENFELD. Are you discussing medical malpractice or all tort laws?

Mr. SHADEGG. Let's stay with medical malpractice. That is the topic. You believe that does not happen?

Mr. ROSENFELD. I can tell you definitively in California it is simply not feasible for an attorney. It would be economic insanity for an attorney who is paid on a contingency basis—unless they are being paid on an hourly basis like defense lawyers. If you are being paid on a contingency, there is no economic advantage to bring such a case.

Mr. SHADEGG. If you get a settlement in that case, you don't get the gain of that settlement?

Let me ask a different question. Does anybody on the panel believe, for example, that meritorious claims should not be paid? Does anybody believe that if you have got a meritorious claim, you should not be able to recover?

All right. Does anybody believe that frivolous claims should be paid?

I think that takes us to a reform that we are not contemplating in this proceeding today and that we should be, and that is some form of loser pays.

First of all, I believe the United States is the only Nation in the world—at least to my knowledge; there may be one or two others I am not aware of, and maybe one of you can bring it to any knowledge—the only Nation in the world that abides by a strict American rule in which losers are not accountable for the cost of the defense of the prevailing party. We call it the English rule, but in fact, it is the rule in all the rest of the world that if you bring a lawsuit and you lose, you are required to pay the attorneys' fees.

It seems to me that the reason—and I have done some review of the literature. This is a Law Review article by the Arizona Journal of International Comparative Law; and in it, it has a lengthy discussion of loser pays and of the so-called "American rule" versus the so-called "English rule," the English rule, in fact, being the rule of the rest of the world, which is losers do pay.

And in that discussion one sentence stuck out at me as something very, very impressive. It said—at the end of the day, basically it said, we are a society that really does not want people to be denied justice because they are not rich enough to pay for it. And I think that is exactly right; I think there is a sense that when you have a loser-pay rule, it would mean that those who cannot afford to bring the lawsuit cannot bring the lawsuit. For that reason, out of fairness, we don't go to a loser-pay rule.

But I would argue that that is making a mistake. I would argue that we should look at loser-pay and say, you know what, there are serious potential problems with loser-pay because it could discourage people without financial resources from bringing meritorious lawsuits.

So why is it we do not proffer language that says the loser shall pay provided, however, that the court shall look at the merits of the claim at the time it was brought, at the reasonableness of the conduct of the attorney who brought it, at the reasonableness of the conduct of the attorney in pursuing it through the litigation itself and may make an award, and take all those factors into consideration? Because it seems to me that in America we do not want to discourage anyone, whether they are wealthy or not wealthy, from bringing a meritorious lawsuit.

But it also seems to me that it is undeniable that the current American rule, which says you can bring this lawsuit and no matter how meritless the claim is, you can take your shot at extorting some kind of settlement and there is no consequence for it—are any of you aware of any State or any country that has looked at some form of a modified loser-pay, that looks at the merits of the claim in determining an award against the losing party?

Mr. ROSENFELD. Congressman, in California that actually was raised as a possibility, that proposal. And they could not work out language in the legislature that adequately protected against those situations in which it was a legitimate case; that, for one reason or another, was not successful. It was that danger that caused the proposal to fail.

Mr. SHADEGG. It seems to me what we are talking about is fundamental reform of the system. It is a system that is abused, but it is a system I believed in. I worked in a tort law firm for a number of years, and I am very painfully aware that the tort system helps people who need help, who don't have resources.

Mr. ROSENFELD. I just want to say, Congressman, that you nailed the fundamental problem with the cap, which is the cap, by definition, affects a nonfrivolous case.

Mr. SHADEGG. That is right. Ms. Lewinski's case is a classic example of why hard dollar caps create very, very serious problems.

I want to ask another question. It seems to me you could also submit a jury instruction which educates the jury on where the proceeds that pay any claim will come from, fundamentally explain to the jury, look, if you make an award in this case, you must understand it will likely come from a fund established by contributions, insurance payments paid by everybody, we all pay for them, so you bring some rationality to their deliberation process.

They could then go on and say, you know what, this is a meritorious case, and I don't care where that fund comes from, it may come from all people who get medical services, but in this case this doctor did something outrageous, such as with Ms. Lewinski, and by gosh, we are going to award a judgment and we are going to award a big judgment in this case, something far in excess of \$250,000, a pretty small sum of money for some of the outrageous kinds of injuries that can occur.

It just seems to me that when we pursue only arbitrary caps as a way to address the kind of problems that exist in this system we are making a grave mistake.

Dr. Palmisano, do you want to make a comment on that? Would your organization be willing to look at other remedies besides regulatory caps?



Mr. PALMISANO. Yes, sir, the American Medical Association, as I stated earlier, has a policy in favor of the MICRA law.

But we also have—last year we formed a committee to look at all possibilities as we go forward. We believe the MICRA law needs to be implemented now. We believe there is an emergency in the United States, certainly in 12 States. We are looking at a number of things.

On loser-pays, we do have a policy on that. We would glad to submit that.

Mr. SHADEGG. I would like to see it.

In the 6 seconds I have, I want to make it clear, I intend to offer a loser-pays amendment. I intend to offer an amendment I offered a year ago on EMTALA, saying if a doctor is forced to give care under EMTALA and that care is not compensated, that it should be the Federal Government that responds in any damages that are awarded against that doctor.

I may offer some form of an amendment dealing with a jury instruction to instruct the jury about awards. It may be, what we ought to be doing is looking at not having the contingent fee come out of the award, but submit the issue of attorneys' fees to the jury after the fact.

I don't quite know why you wouldn't say after a defense verdict, let's—turn to the jury and say, you awarded the defense verdict in this case. Do you, the jury, believe this was a frivolous lawsuit that shouldn't have been brought, in which case you are going to award attorneys' fees against the losing party; or do you, the jury, believe when they brought this lawsuit, it appeared to be a pretty meritorious lawsuit and the plaintiff's attorney was reasonable and you are not going award any attorneys' fees against the losing party and in favor of the defense party?

It seems to me we can be more creative in this process. I appreciate the time.

Mr. GREENWOOD [presiding]. The gentlelady from California, Mrs. Capps.

Mrs. CAPPS. I think it is so important for Congress and this committee to address barriers to the access to health care. Thank you for holding the hearing. I thank my ranking member Mr. Dingell for yielding his time to me, so I could go ahead.

One emerging barrier seems to be the rise in medical malpractice insurance rates that are taking place in various parts of this country. I want to associate myself with the remarks made by Henry Waxman and Anna Eshoo, my colleagues from California, and also my colleague from Texas, Mr. Green, that these are cases which are tried in State courts. Doctors are licensed by States; I think it is appropriate that this matter be handled by States, as it isn't very many.

And also my colleague, Ms. Eshoo, who noted that if there is great inertia when setting caps or fixed awards, inertia about raising them according to the adjusted cost of living, that the \$250,000 cap in California is actually worth about \$68,000 in today's money.

That being said—and, Dr. Palmisano, I am pleased that you are here representing the AMA and doctors in our country, many communities are asking serious questions about how they can keep their doctors in their communities. And the question we have to

ask is why doctors are increasingly leaving the field and showing their dissatisfaction.

Your counterpart in California, the medical association, recently surveyed doctors; 75 percent of those who responded described the practice of medicine as being less satisfying now than it was 5 years ago, only 9 percent find it more satisfying. Another finding: 53 percent who are dissatisfied cite low reimbursement rates and 53 cite managed care hassles as the causes, both topics in which we have a role to play in Congress.

I live in California. This is very disturbing news for those of us who get our medical care in that State. Yet this is the State where we have had medical injury compensation reform, MICRA, for almost 30 years. Now, there is still serious debate, and I am happy we are engaging in it, about why premiums are rising and what should be done to stem that growth. Insurance companies argue that we need to limit noneconomic damages to patients who have been harmed by a doctor's mistake or negligence.

At this point I want to thank all of our expert witnesses for your testimony today, but I want particularly to thank Heather Lewinski. Your bravery did not go unnoticed by me. And if it is your family that is with you, they can be very proud of what you have done with a very horrible experience in your life. You are sitting before us, and testifying is hard, it is nerve-wracking—it is even for me, being on this side of the aisle—not for any gain that will benefit you, but because of what you personally have gone through. And you are, to me, such a fine example of someone whose true spirit comes from within and who will take a very horrible time in your life and experience and negligence and make something positive for someone else out of it.

And I hope that is the case, and I wish you well. You are such an example to me of how this legislation could penalize innocent victims of medical negligence.

Discriminating as it is against children, moms who stay at home, people who have disabilities and people who earn low wages. It says what we are going to do if we pass this legislation is that the health and well-being of a corporate CEO is worth more than the health of a janitor or a janitor's child. Because economic damages are based on wages, the CEO would get more money in damages.

Noneconomic damages would make—are the only real guarantee for to us make sure that everyone can be treated fairly.

There is a very prominent case in the news now that is going to really provoke a lot of discussion on this topic. If I could turn to you again Dr. Palmisano, you are a doctor, and I don't have to remind you of your Hippocratic Oath. I am a nurse, and I think we see things very clearly in this arena. You have just heard the story of Heather Lewinski; you know there are other stories like hers.

I will ask you point-blank so you can answer for the record: Do you think she was well served by her doctor?

Mr. PALMISANO. Well, obviously, from what she has told us, she was not well served by her doctor. It is tragic whenever someone is hurt through negligence.

Mrs. CAPPS. All right.

To go on, her doctor and his insurer paid the damages. Do you think he should be allowed to continue to practice medicine after

what has happened to Heather and her family? Do you think there should be have been any disciplinary action taken against him?

Mr. PALMISANO. I think the American Medical Association supports strong State board medical examiners to review, in fact, in every case where there is payment in a medical malpractice case, that goes before the State board of medical examiners. It is mandatory reporting. We should have State boards to look and see whether or not a doctor needs to be removed from practice.

Mrs. CAPPS. With the number of cases before us in this country, a small percentage of which are reported and acted upon, perhaps that is something that should be strengthened. But in this case, Heather's story, she received no economic damages in her suit because of her age. Under the proposal and the legislation before us, she would have received only \$250,000. Instead, the court awarded her noneconomic damages of more than a million because the jury and the court system that saw and tried this situation felt that that was appropriate. Do you think it was too high?

Mr. PALMISANO. As far as—do I think what was too high?

Mrs. CAPPS. The award that she was given.

Mr. PALMISANO. I don't know what the award was.

Mrs. CAPPS. It was a million dollars. Am I right?

Ms. LEWINSKI. The jury awarded me \$3 million.

Mr. PALMISANO. Well, you can't put a price on life. You can't put a price on serious injury. What you have to do is try to balance what you are going to do if you can't compensate—if you can't take care of the rest of the American public.

Mrs. CAPPS. I want to underscore the sentence you just said. You can't put a price. But that, in effect, is what this Congress is attempting to do with this.

And it is my understanding, Ms. Lewinski, that you actually had to settle for quite a bit less.

Ms. LEWINSKI. Yes, because of the lack of insurance that the doctor had.

Mrs. CAPPS. Because of the amount of insurance that the doctor had. Keeping in mind that you have had 14 subsequent surgeries, and who knows what will be awaiting you in the future of your life? This is something that only you know.

Again, we have a jury system that is designed for the story to come before a jury of your peers or of your parents' peers to make this case.

If I could now turn to you, Mr. Rosenfield, and ask you about sincere—my California, one of my California representatives there to see—and I don't have much time left—since MICRA—would you say this again, what have the rates of malpractice insurance done in those first 13 years?

Mr. ROSENFELD. The premiums for doctors went up 450 percent after MICRA was passed, through 1988.

Mrs. CAPPS. Is there anyone on this panel who believes that MICRA by itself capped—did anything to affect the insurance premiums in California?

You do. Okay. Well, that is a little bit of a pull right there.

For some reason, Mr. Rosenfield—and you were instrumental in this—Proposition 103 passed, which meant that all of the voters in the State of California had to approve something, which meant

they didn't quite trust this insurance industry as it was self-regulated.

After Prop 103, was there any sign of malpractice insurance companies leaving the California market in response to this effort to control them?

Mr. ROSENFELD. No.

Mrs. CAPPS. Thank you very much. Thank you for my time. And I will yield back what I don't have left. Thank you.

Mr. GREENWOOD. Mr. Buyer is recognized for 8 minutes.

Mr. BUYER. Mr. Waxman brought up a point—you know, both political parties have to be relatively honest here. We do like to pick and choose when the Federal Government should act and when they shouldn't. We really do. And so Republicans are no different than when Democrats were in the majority. They would pick and choose and use the Commerce Clause when to act and when to defer to the States.

One thing that has worked well—as I have observed as I look at Mr. Dingell that I am a relatively young bird here, but he has seen this in his lifetime—when you look at how we establish EPA, you set out the guidelines, then you turn to the States and you let them go ahead and conduct their own environmental, but they can have stricter standards. It is a system that sort of works well. So all we do pick and choose.

I am not going to get sucked into this debate today about cap and a cap, only a cap.

I am somewhat bothered by where the debate has really gone today. I come from a State where I am very pleased that the atmosphere is pretty good. When I look back on this one, medical malpractice in the 1960's was liberalized by legislatures. There was a destabilization that was occurring in the early 1970's. Indiana responded because we had an exodus of doctors. So in 1975—we had a Governor at the time who was an M.D., Dr. Otis Bowen—and I believe that what came out of that legislature is really a model.

Now, I am not king and, boy—but if I could say what would be wonderful—obviously, I come from Indiana—boy, if every State had what Indiana has, Congress wouldn't need to act.

So I guess we have members from different States today that have been saying unto this panel, Oh, comment on this particular cap and tell me why the premiums have increased and why they haven't. It isn't just about caps. I sat here and sort of made some notes as I was pondering about this, and I think that there is just a series of interrelated problems that involve regulation, that involve the social control of medical practice. There is the quality of care, of insurance markets, there is consistent assessment liability laws, there is the existing paradigm of the social attitudes toward the practice of medicine.

So the question of the equitable and efficient solutions to the series of problems involves, I think, action on multiple fronts. So you can't just say, well, legislature, what you ought to do is just throw out a cap there.

So Indiana didn't just throw out a cap. Some States may have just thrown out a cap. What we did was, we intensified the peer review system. So I tell you what, in Indiana we—yes, there are some limitations on claims, but we went ahead and we placed a

limit and said, it should be no more than \$1.25 million. But then we come in and go, you know what, we are going to create a compensation fund.

So we have this government-sponsored system whereby the doc is responsible for the first 100,000 and his insurance company, but we then have a patient's compensation fund.

We also have a medical review panel. So we are focusing on uplifting the standards of practice also.

So this whole question today about changes in legal doctrine may not likely reverse the current trend. That is the reason some of my colleagues threw up a chart earlier and said, look at all these different States out there that have caps. There is no impact on premiums whatsoever. What are we doing with caps? My gosh, if those States out there are unwilling to take on multiple fronts—well, of course.

But I do have a chart. Would you throw up my chart? Who has got it? If the panel would turn around and look at this for just a second, what I have attempted to do here is look at Indiana and our contiguous States. Now this comes from the Medical Monitor, the Liability Monitor everybody is citing, and these are, I apologize, 2000 figures. But what I attempted to do here was use the lower numbers.

[The chart follows:]

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Mr. BUYER. For Illinois, for example, you could go to Cook County, Chicago, and the OB is like 89,000; surgery was 54,000, and internist was 22. I tried to use the lower numbers.

But here is my point. What is occurring in Indiana where we have a good system that addresses not only costs but medical review, peer review, quality assurance; not just throwing out some form of a cap, but a compensation fund system, look at the impact it is having. So where before we had doctors leaving our State, when you look at having a system like this and you have contiguous States, guess what we have? We have an influx of doctors to Indiana. That is a problem.

So I am challenged at the moment, because I love States' rights. And now we are having to review this, saying, well, we are going to have the Federal Government come in and set standards, but look at the mess we are creating out there across the country. And I just think it is horrible.

I want to ask, is anyone on the panel familiar with Indiana's laws? Are you? And I appreciate your comments on my comments today.

Go ahead, please.

Mr. PALMISANO. Well, we are very familiar with the Indiana law as was originally proposed, because that is where Louisiana, Dr. John Cooksey, who was formerly in Congress, he got the idea of bringing Senator Benjamin down to Louisiana. And several of us met with Senator Benjamin. He explained how your law was passed, and we then introduced that law into Louisiana as Act 1465 and it became Act 817 of 1975. It was a total cap on all damages as was the law in Indiana.

It also had the medical review panel, so before you could file a claim, you had to go before a medical review panel. The plaintiff would pick one doctor in the same specialty, the defendant would pick one doctor, the two doctors would pick a third. Then there was an attorney who had no vote to make sure that everything went by the appropriate statutory requirements.

And then—so you have a patients' compensation fund. You paid a percentage of your premium for—the first 100,000 went into the patients' comp fund. That was a total cap. That gave another \$400,000.

Since that time—I don't know if I am saying too much—but Louisiana, we then modified our law more like New Mexico, where we pay all medicals as incurred.

Mr. BUYER. There are some saying if you have a medical review panel, you will have an increase in scrutiny, and all that is going to do is lead to costs because you will have defensive medicine, you will have doctors asking for more tests and procedures.

But, you know what, the reverse has happened in Indiana. These doctors are now focusing more on their patients and not having to worry about that. So you may have some States out there, I am just—my editorial comment, people throwing out, this State has this particular cap and you have got this cap and you have got this cap. If you are not addressing this continuum, obviously you are not going to affect these insurance rates whatsoever. This is my own feeling.

So I am glad to see what Louisiana has done and Indiana. And these States have to do more than just throw out some cap on something.

Do you have a comment, Mr. Smarr?

Mr. SMARR. Yes, sir, I do.

The Indiana cap right now is a \$1.25 million cap on all damages of any kind. And I believe the primary insurance carrier provides the first \$250,000 in coverage and then the compensation fund provides a million in coverage on top of that.

Just a word about compensation funds. Your fund in Indiana is unfunded, basically. It is a pay-as-you-go mechanism. It has a huge outstanding incurred loss for claims that are going to be reported to it for coverage that is offered. There is a similar fund in Pennsylvania that ran into huge problems with its unfunded liability and the surcharges to fund that fund became astronomical.

Mr. BUYER. Our legislature addressed that. I know my time has expired, but we have addressed the underfunded.

Thank you, Mr. Chairman.

Mr. GREENWOOD. The Chair thanks the gentleman.

The gentleman from Michigan, the ranking member, Mr. Dingell.

Mr. DINGELL. I commend you for holding this hearing.

I want to begin by saying, Ms. Lewinski, we appreciate your courage and your presence this morning. I believe it is very important that this hearing reflect some of the human experiences which are involved in the questions before us.

I want to welcome you, Dr. Palmisano. I have great sympathy for the concerns that you have expressed as you very well know.

I want to thank you, Ms. Rosenbaum, for being here. And Mr. Rosenfield, you have been of help to us before.

Ms. Rosenbaum, I will direct my first question to you. Ms. Rosenbaum, you are a law professor. You have tried lawsuits. How long have you been in this business?

Ms. ROSENBAUM. I have been a lawyer now for almost 30 years.

Mr. DINGELL. Your comments were very interesting about how this bill preempts State and Federal law and literally preempts any possible lawsuit against almost anybody. And I found your testimony with regard to who gets out from under these lawsuits to be very interesting.

In the case of State laws, you referred to questions relating to fraud and deceit, unfair trade practices, civil rights laws, labor law, including workers' rights protections, criminal law, consumer protection, antitrust laws and environmental laws.

Are you sure you are right on that?

Ms. ROSENBAUM. I can only testify to what I read in this bill.

The charge to me as a witness was to take a close look at the legislation. And reading the legislation, the kind of health law I teach has me spending a great deal of time on the text of legislation. Reading the text of this legislation which is very broad and with very few definitions—

Mr. DINGELL. Let me try to make this a little quicker. It is almost—there is no exemption—

Ms. ROSENBAUM. Exactly.

Mr. DINGELL. [continuing] from any of these things with regard to the States; is that correct?



Ms. ROSENBAUM. That is correct. And, for example, the word "any person" is not modified to take public officials out of the phrase, "any person."

Mr. DINGELL. So then I note that you have here examples of—Federal law. Apparently covered are fraud and abuse, RICO, false claims, antitrust, Sherman-Clayton Act, civil rights laws, criminal statutes, Federal food and drug laws, Federal environmental health laws, Federal labor laws, Federal contract enforcement laws that provide for liquidated damages, restitution to the extent that restitution is not understood to be a part of economic damages.

Do you make the same statement with regard to Federal laws too?

Ms. ROSENBAUM. I do.

Mr. DINGELL. Now, Dr. Palmisano, I can sympathize with the problem that you and the members today at the AMA may have. I have had many of my doctor friends, who have talked to me about their concerns. I believe that they are legitimate and real. You are not here advocating that we go beyond addressing the problems of health, are you?

Mr. PALMISANO. No, sir.

Mr. DINGELL. Are you familiar with the testimony of Ms. Rosenbaum?

Mr. PALMISANO. Just what I heard today. I haven't reviewed it in advance.

Mr. DINGELL. You don't endorse that kind of broad exemption, do you?

Mr. PALMISANO. No, sir. We talk about what is on page 19 of the bill that relates to the diagnosis, prevention, treatment of any human disease or impairment of the assessment of the health of human beings. In other words—

Mr. DINGELL. Your concern here is about legitimate questions of health and legitimate protection of people who are legitimate deliverers of health care; is that right?

Mr. PALMISANO. Yes, sir.

Mr. DINGELL. Now, Mr. Smarr, I found your comments to be very interesting. You are appearing on behalf of the insurance industry, is that right, and are active in one of the associations which addresses the problems of insurance, is that right?

Mr. SMARR. Yes, I am appearing on behalf of the provider-owned or -operated malpractice insurance company.

Mr. DINGELL. Now, are you advocating the kind of broad exemption here that Ms. Rosenbaum has defined as being a real possibility?

Mr. SMARR. No, sir, we are not.

Mr. DINGELL. That would be wrong, wouldn't it, to give exemption from civil rights laws, environmental laws, consumer protection laws, labor laws, antitrust laws, fraud and abuse under RICO, or the False Claims Act, Federal environmental laws, Federal labor laws? We shouldn't give exemptions there, should we?

Mr. SMARR. This is the first time that I have heard of these issues, and so I am hesitant to comment on it. But on the face of it, yes, you are correct it would be wrong to exempt people from those laws.

Mr. DINGELL. You have read the bill and they apparently snuck this in on you too, didn't they?

Mr. SMARR. Well, I don't know that that's what the bill says. I would have to have a read of it.

Mr. DINGELL. You didn't see it there?

Mr. SMARR. I didn't see it there.

Mr. DINGELL. But I don't detect that you are ready to argue with the professor of law, are you?

Mr. SMARR. No, sir, I am not.

Mr. DINGELL. Now, Mr. Rosenfield, what do you think about this? Is it your view that this is something which relates to the matters that have been discussed by Ms. Rosenbaum?

Mr. ROSENFIELD. Well, it reminds me of that little deal that the Senate passed exempting in the Homeland Security bill, exempting certain manufacturers of vaccines. I think it is something that is stuck in there and everybody hoped that we wouldn't see it until was too late. I am glad you are calling attention to it.

Mr. DINGELL. Would you generally agree with what it is that Ms. Rosenbaum has said here with regard to this piece of legislation?

Mr. ROSENFIELD. That is our analysis, yes.

Mr. DINGELL. I read it, and with profound regret, I think that somebody is trying to pull the wool over the eyes of the committee here. And it looks like there may have been some sneaky draftsmanship here.

Not referring to you, Mr. Chairman. I have great respect for you.

But that some slippery soul outside the committees' tutelage may have engaged in a little bit of doubtful practice here. And I find that to be a very troubling, very troublesome situation.

I would note, Ms. Rosenbaum, that at page 21 I see here other Federal law, "Except as provided in this section, nothing in this act shall be deemed to affect any defense available to a defendant in a health care lawsuit or action under any other provision of law." That would tend to add to the sweep and the breadth of this exemption in all kinds of wrongdoing which we have seen in the bill before us; am I correct?

Ms. ROSENBAUM. That and the saving of the vaccine injury claims led me to my conclusion that everything else was preempted.

Mr. DINGELL. In other words, we would use here the old legal interpretation of *expressio unius est exclusio alterius*; is that right?

Ms. ROSENBAUM. Exactly.

Mr. DINGELL. I wonder, we ought to have—I think Mr. Chairman, we do need to have some more hearings on this matter. And I want to commend you for this hearing. What other witnesses, Mr. Chairman, do we have coming in? Do we have government, somebody from the Attorney General, somebody from HHS who would be able to help us wander through this thicket and perhaps guide us in some appreciation of just whether some really slippery rascals are going to get out from under the law here?

Mr. BILIRAKIS. I would remind the gentleman—your time is up, but I would remind—

Mr. DINGELL. In order to show my respect for the chairman I ask for 2 additional minutes so that you can tell us if we are going to have some more hearings here.

Mr. BILIRAKIS. I plan to go into a second round, very brief second round, hopefully limiting it just to the people who are in the room right now.

Mr. DINGELL. Well, that's splendid, Mr. Chairman, I would observe. But I am profoundly saddened by the fact that our witnesses here agree with me that this is a bad piece of legislation because it gives all of these profound exemptions from law to a bunch of people who are not here to say they need this help, and we don't have the assistance of people from the Attorney General or the Department of HHS or the Federal Trade Commission or the SEC. And I really think we ought to know whether these matters are, in fact, valid because it looks like there is some slipperiness going on here, Mr. Chairman.

Mr. BILIRAKIS. Markup is scheduled next week, as you already know, No. 1. No. 2, we gave the minority the opportunity—I wanted to delve into things like insurance in this particular hearing, and we gave the minority the opportunity. They didn't bring in a single insurance witness that might set out their particular point of view, which is—so—

Mr. DINGELL. Well, you see, we didn't know what Ms. Rosenbaum was going to have to say to us. What she has said here is very, very—

Mr. BILIRAKIS. We have also had other witnesses who have had other things to say to us, who are supportive of the legislation.

The gentleman's time has expired. Let us just go in regular order.

Mr. DINGELL. The other witnesses totally disagree with Ms. Rosenbaum.

Mr. BILIRAKIS. With all due respect, we are going to go into a quick second round limited—you have 8 minutes don't you? That takes care of our second round I think.

Mr. DINGELL. All but me, Mr. Chairman.

Mr. BILIRAKIS. Mr. Strickland has—

Mr. STRICKLAND. I have 8 minutes, Mr. Chairman.

Mr. BILIRAKIS. You have 8 minutes.

Mr. STRICKLAND. And if my good friend will promise me he will limit his remarks to 2 minutes I will yield 2 minutes of my 8 minutes to Mr. Dingell, so that he can continue his questioning.

Mr. BILIRAKIS. You are very free to do that.

Mr. DINGELL. I thank my good friend. I don't want to take the time away from him. I know the chairman is going to very generously give me my additional time on the second round, so that I can continue discussing these matters.

Mr. STRICKLAND. Reclaiming my time, Mr. Chairman, I did not make an opening statement, but I—before I ask my questions, I would like to say something that just, to me, is the core conflict which I face as a legislator in this matter of caps. And if I could settle this inside myself, I think I perhaps could take a different position than I have taken.

But in this country, we use the jury system to make life-and-death decisions. In the State of Texas we execute people frequently, and we are going to execute people in the State of Ohio, based on the decision made by a jury. And in fact, the President has said that he is confident that no one has been executed in Texas that

was not guilty; and he has made that assumption, based on the decision of a jury. And it troubles me that we would allow the jury system to be so valued and utilized in a way that they could actually make a decision regarding taking the life of another person, and yet, when it comes to monetary matters, when it comes to money matters, we don't trust the jury system.

We say, somehow it is flawed, it is broken, it can't be trusted. Now, I don't know how to deal with that. I just don't know how to deal with that personally. I struggle with this matter. And I am open to questions or suggestions or to information that could help me resolve that internal conflict.

Ms. Lewinski, thank you for being here. And I hope you understand how important your testimony was to all of us. As a result of your injury, did you receive any economic compensation?

Ms. LEWINSKI. Strictly pain and suffering, yes.

Mr. STRICKLAND. But not economic compensation?

Ms. LEWINSKI. No, sir.

Mr. STRICKLAND. So the only compensation you received was based upon pain and suffering, which is a noneconomic matter?

Ms. LEWINSKI. Right.

Mr. STRICKLAND. I am going to ask each of the panelists a question, and I think it is a fair question. And I am going to ask you to answer yes or no, or I need more information.

Do you think—and could we just go down the line? Do you think that Ms. Lewinski was entitled to no more than \$250,000 as a result of her injuries?

Mr. HURLEY. I am here as an advisor. I would prefer to advise.

Mr. STRICKLAND. But I think you are here to give testimony, which will have an impact upon a decision that we make that could relate to how much compensation someone like Ms. Lewinski gets; and so I believe it is fair to ask for your personal opinion about this matter.

Mr. HURLEY. I am deeply saddened by the experience that Ms. Lewinski had, and I favor patient safety initiatives and all those things to try and make things better from that standpoint.

But I think the dilemma for legislators like you is to determine what the balance is between compensating on noneconomic damages, and any other type of damages for that matter, against providing health care for everyone, and making health care more broadly available. So that is the dilemma.

My opinion is, we need to make a compromise somewhere. I don't know where that compromise is. Unfortunately, that is your decision, not mine.

Mr. STRICKLAND. But would your personal opinion be that that level of compensation should be \$250,000?

Mr. HURLEY. I don't have an opinion on what the right number is, sir.

Mr. STRICKLAND. Do you not have an opinion, sir, or do you not want to share it with us?

Mr. HURLEY. I have not formed an opinion about the number, to be honest with you. That is my—that is absolutely my honest answer. I have not formed an opinion about what the right answer is from my standpoint.

Mr. STRICKLAND. Mr. Hiestand.

Mr. HIESTAND. I would like people to get as much money as they could get in an ideal world for their injuries, but I don't believe that that can be done.

And in relation to your earlier concern that you expressed about tying juries' judgment, juries have to make decisions according to the rules of law, as you know; and one of the ironies I have always found in this—as a lawyer, is that if a lawyer commits malpractice on someone, depriving them of their liberty or their property, you know what the limit on noneconomic damages is for that injured party.

Mr. STRICKLAND. You know, sir, I don't. But——

Mr. HIESTAND. Zero.

Mr. STRICKLAND. But I feel like you are avoiding my question. It is a very simple question about a very particular circumstance, and you are here urging us to support H.R. 5, which will have an effect on someone like Ms. Lewinski. You have an obligation, I believe, to answer a simple question. I am asking you a very simple question.

Mr. HIESTAND. I believe that what California did in setting the amount at 250,000, what Congress did at setting it——

Mr. STRICKLAND. You are not answering my question.

Mr. HIESTAND. This is the answer: The 250,000 which Congress also set as a limit for what is paid for noneconomic damages to the survivors of the 9/11, and then currently——

Mr. STRICKLAND. We are not talking about 9/11. I am talking about——

Mr. HIESTAND. I am talking about the amount, 250,000.

Mr. STRICKLAND. With all due respect, sir, I am asking a very simple question.

Ms. Lewinski has provided us with testimony about her circumstances. It is an individual circumstance. The law we are considering will impact individuals, and I am asking you about this individual circumstance.

Do you believe that what has happened to her is a situation that should require her to be paid no more than \$250,000? I think that is a simple question. And if you need more information, say, I need more information; I am not going to answer it yes or no.

Mr. HIESTAND. Well, it is a two-step answer, and the first answer is, as a person, as an individual, as I said at the beginning, I favor unlimited compensation for people who have injuries.

If I was a lawmaker, like you are, and I have to make a decision to try to balance how you are going to prevent malpractice or restore people to whole and at the same time keep access to your health care system, I favor setting some limit on noneconomic damages.

Mr. STRICKLAND. Okay. If I can stop you there.

And before I ask the others to respond, do you think MICRA was a good law when it was passed?

Mr. HIESTAND. Yes. It is a good law today.

Mr. STRICKLAND. Do you think the level of compensation was an appropriate level of compensation when it was passed into law?

Mr. HIESTAND. Yes.

Mr. STRICKLAND. Do you favor having that \$250,000 indexed so that it would have the purchasing power today that it had at the time was passed into law?

Mr. HIESTAND. No, because that amount today would be in excess of \$800,000 if it was indexed.

Mr. STRICKLAND. If the purchasing power is the same, explain to me why the purchasing power when it was passed was appropriate and it would not be appropriate today to have the same—

Mr. HIESTAND. Two answers. First, the experience in California is that even with the limit of 250,000, people who sue for medical malpractice today are getting more adjusted for inflation than they were getting before the \$250,000 limit, more in the overall judgment, because the economic damages—lawyers have become very good at getting them up to make up for that.

Mr. BILIRAKIS. You are past your 8 minutes.

Mr. STRICKLAND. Are my 8 minutes up?

Mr. BILIRAKIS. Oh, yes. You are into your 9th minute.

Mr. STRICKLAND. Well, I am sorry because I wish—

Mr. BILIRAKIS. Well, if you hang around, Ted, you will get another shot.

The gentleman's time is up. I am being reminded that I have 3 minutes.

Does anyone disagree that—let's not go into, for the moment, in terms of what the solution might be or should be or whether it should be left completely up to the States or whatever the case may be. Does everyone agree that there are problems out there that would require enacting medical liability reform of some sort?

And we haven't even touched on it here, but when we used to talk about this subject, we quite often talked about how it increases the cost of medical care because of all of the additional tests and whatnot that have to take place, that physicians feel have to take place in order to protect themselves. Do we have any disagreements there?

You disagree? Heather, you have been listening to all of this. I guess it has probably been a little bit of an education to you. Do you—let's not go to 250,000 or 800,000 or whether there should be a cap. But do you understand the need for something to take place because a lot of doctors are leaving professions, a lot of doctors are leaving geographical areas, going to another geographical areas, things of that nature—access, in other words, being a problem. OB/GYNs are not as available these days; do you agree?

Ms. LEWINSKI. Yes, sir. But I think you are going after the wrong people, the victims instead of the real problem.

Mr. BILIRAKIS. And the real problem is the doctors?

Ms. LEWINSKI. I am not—I am just not sure why the doctors don't want to weed out the bad ones. I mean, the majority of doctors are good. Why don't you want to weed out the bad doctors?

Mr. BILIRAKIS. Yes. You said that in your written statement, which is fair.

Mr. Hurley, a real quick comment because I don't have much time. You agree that something has to be done? I believe you do.

Mr. HURLEY. I believe that you need to look at some solutions.

Mr. BILIRAKIS. Yes. Mr. Hiestand?

Mr. HIESTAND. Yes.

Mr. BILIRAKIS. Mr. Rosenfield, I know you don't believe. I don't want to know your answer, you just don't believe, because I don't have time.

Ms. Rosenbaum.

Ms. ROSENBAUM. I would recommend a complete alternative to the current system.

Mr. BILIRAKIS. But something being done, yes.

Ms. ROSENBAUM. Yes.

Mr. BILIRAKIS. Right.

Mr. BILIRAKIS. Mr. Smarr?

Mr. SMARR. Yes, I do believe something needs to be done.

Mr. BILIRAKIS. And Dr. Palmisano?

Mr. PALMISANO. Yes.

Mr. BILIRAKIS. I don't have enough time to ask you to tell me what you think should be done, but I would like to invite you and someone over here—I think asked Ms. Rosenbaum, Mr. Norwood. But I would like to invite you—if you feel that something ought to be done; if you feel that nothing needs to be done, then you don't have to submit anything—give you the opportunity to let us know in writing how you think we ought to approach this.

I mean, you are experts here, and I—you know, we do have biases. We are human beings and many people on the other side have biases and they are accused by many of being for it, in the pocket of the trial lawyers.

Mr. Waxman has already said that the Republicans are basically biased for the insurance companies. There may be some truth in all of that. But I would like to think that we sincerely want to do something that will help to solve the problem. So I invite you to do that.

Having done that, I yield 3 minutes to Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Do you want the 3 minutes now Mr. Dingell? You have that right.

Mr. DINGELL. No, I will wait.

Mr. BILIRAKIS. Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman.

Mr. Smarr, as I understand it, there are different risk groups for doctors and, in fact, in one of the charts Mr. Buyer put up, you saw that some doctors pay much higher insurance rates because they are in different risk groups than other doctors. For example, OB/GYNs, neurosurgeons, folks like that, pay substantially higher insurance rates than, say, family practitioners; is that correct?

Mr. SMARR. That is correct.

Ms. DEGETTE. And a lot of the crisis that we have seen in malpractice insurance rates has been with these doctors who are paying high premiums in high-risk groups, right?

Mr. SMARR. They are experiencing it greater than the others; that is right.

Ms. DEGETTE. Now, as I understand it—and unfortunately, I couldn't be in Pennsylvania; I had another obligation in my district. But as I understand it, some of the conversation in Pennsylvania said, if you spread the risk out among all doctors, that the lowest-rate doctors in Pennsylvania would end up paying like \$5,000 to \$7,000 more per year in malpractice insurance premiums. But then

the high-risk groups would be lowered if you spread them out over different polls; is that correct, Mr. Smarr?

Mr. SMARR. The direction of change is correct. I am not—I don't know about the order.

Ms. DEGETTE. But, I mean, it makes sense.

And, Mr. Rosenfield, you—even though they say you are not an expert on insurance, I know you are an expert on insurance, so I would just like to set the record straight for that. But my understanding is that if you spread the risk out, some people, some doctors' insurance might go up a little bit, but the highest-risk doctors' insurance would go down substantially; would that be correct? Just very short.

Mr. ROSENFELD. Yes.

Ms. DEGETTE. Thank you. Because here is what I am sitting here thinking. When I hear Mr. Hurley and Mr. Hiestand and all these folks saying we really think there is a problem—and I agree there is a problem; no one doesn't think there is a problem. The question is, who should bear the burden? And here is the thing I am thinking.

Ms. Lewinski, or the lady who, through medical malpractice, had both of her breasts amputated needlessly, or so many other victims that may not have high economic damages, why should we limit their noneconomic damages to \$250,000 arbitrarily when they may have substantially higher damages, but we are limiting them?

But we are saying to doctors, we don't want to make people with low—in low-risk groups just pay a little bit more insurance premiums to help their colleagues in higher risk groups? I think that is appalling that we, as Representatives of the American citizenry in Congress, would make that value judgment to say to these victims, you are arbitrarily capped. You might have noneconomic damages of millions of dollars, but you only get this much.

But doctors, forget it. We don't want you to have to pay higher insurance rates nor do we want to examine the insurance industry.

And I am even more opposed to this bill, if possible, than as I was before. I told my dear friend I would be willing to try to work with them on this, but I just think this is the totally wrong road to go down. Thank you for your comity.

Mr. GREENWOOD [presiding]. Well, and I wanted to make a comment just to respond to my friend, Mr. Strickland, with regard to juries and how much leeway they have. Our jury system is critical and almost sacred in our country, but I would also note that we give juries the right to determine fault and we give the juries the right to determine the ability to determine guilt, but we don't say—we don't give juries, for the most part, unlimited abilities to—with regard to sentencing, for instance. We don't say, you can execute someone for shoplifting and so forth.

Mr. STRICKLAND. Will my friend yield just a moment?

Mr. GREENWOOD. I will yield to you, but just let me finish my thought here, if you would.

So I think, in fairness, this is not about whether we remove the jury system from its deliberations to determine where there is fault in a case and so forth. But what we are trying to do is, as Mr. Hiestand said, set some limits to have justice and affordable health care and available health care.



Mr. STRICKLAND. Can I respond in 10 seconds?

Mr. GREENWOOD. Ten seconds.

Mr. STRICKLAND. Some juries recommended death or life sentences. That is a pretty weighty decision. And I think as long as juries are trusted to make those kind of decisions, they should be trusted to do that.

Mr. GREENWOOD. Reclaiming my time, I understand the gentleman's point. The point I was trying to make is that this is not an alien notion that there would be some limits imposed by lawmakers on the discretion available to juries.

The other point I think that needs to be made is there has been a constant repetition of the \$250,000 figure. It needs to be understood that the \$250,000 figure is there, in part, because it is what has worked in California. It is there, in part, because the California delegation, many of them, felt that they didn't want us to trump their existing cap, and so we have allowed the States to set that cap wherever they wanted.

So, my friend Mr. Waxman talked about States' rights. We were very clear in this legislation that any State legislature in the country that wants to set noneconomic damage at a number higher than 250, whether it is \$500,000 or \$750,000 or \$1 million, wants to decide to move it periodically with time and so forth, is certainly free to do that.

Now let me try to wedge a question in here for Mr. Smarr, and referring to Ms. DeGette's comment that has to do with rating.

Do you have any recommendations with regard to—because this question comes up a lot. Is it—do we have any structural problems, with the physician-owned companies at least, that have to do with classes of coverage being too small to actuarially rate fairly, with giving different rates to physicians that have more claims paid because of their malpractice than others? How does that work?

Mr. SMARR. Each company looks at its insureds usually by medical specialty and then by a geographical unit, such as a county—and this is true of a lot of lines of insurance; auto insurance, for example—and assigns relativities to each type of insured, based upon the loss experience within their medical specialty, or group of specialties, and within their county or group of counties and territories to try to fairly charge each individual doctor in proportion to his or her losses for the type of practice they have.

In addition—

Mr. GREENWOOD. My time has expired. But—so if physician A has had more losses as a result of settlement or judgments than physician B, and they are in the same county in the same specialty, do they tend to pay different rates?

Mr. SMARR. They indeed can. Through other mechanisms, the insurance companies offer to do merit rating, and that is not an unusual concept.

Mr. GREENWOOD. Thank you. My time has expired.

The gentleman, Mr. Dingell, is recognized for 3 minutes.

Mr. DINGELL. Mr. Chairman, thank you. I wanted to just go into this business, the definition of health care provider who would be sued, or health care organization.

Where is there a limitation on who might fall into that particular category of persons in the legislation? Is there one, anywhere?

Ms. ROSENBAUM. I saw none.

Mr. DINGELL. Maybe—Mr. Smarr, you are our expert on insurance. Do you find any limitation on who that individual might be?

Mr. SMARR. I have not looked at this, so I can't comment sir.

Mr. DINGELL. Should there be a limitation on who would get out from under the liability here, Mr. Smarr?

Mr. SMARR. Well, the legislation, I think——

Mr. DINGELL. No. No.

Mr. SMARR. [continuing] addresses who is covered by——

Mr. DINGELL. The question is quite clear. And there are 13 sections left?

Mr. SMARR. I don't know.

Mr. DINGELL. Who would be able to tell us?

Mr. ROSENFIELD, maybe you can help us. Do you find any limitations on who gets out under this liability here?

Mr. ROSENFIELD. No.

Mr. DINGELL. Is there anybody that finds any limitations on any fellow that gets out from under it?

Mr. Hiestand, maybe you are a better lawyer than all the rest of us here.

Mr. Hiestand. I understood Dr. Palmisano is also a lawyer, referring to page 9 of the——

Mr. DINGELL. I am not sure Dr. Palmisano wants to get into this discussion.

Do you want to get into this discussion, Doctor——

Mr. Hiestand. On page 9 of the bill, it ties it in in terms of medical and health care services and goods.

Mr. DINGELL. But who is defined?

Mr. Hiestand. Diagnosis and treatment and I think that is the limitation. And I mean, the professor may be right that that is not confining enough. But I think the intent of the legislation was to limit it.

Mr. DINGELL. When I was in law school, I didn't argue with my professor.

Mr. Hiestand. Pardon?

Mr. DINGELL. Are you a lawyer?

Mr. Hiestand. Yes.

Mr. DINGELL. You are. Did you ever argue with your professor? I was always taught not to.

Mr. Hiestand. I sometimes argued with my professor, but you know, it is not a winning kind of thing.

Mr. DINGELL. Where is the language that you would rely on to exempt some person, rather to remove them totally.

Mr. Hiestand. Dr. Palmisano has it scored in yellow over there at the top of the page. If he could sort of read that——

Mr. DINGELL. If you tell me it is there, it must be there. I am just waiting to hear you tell me what language you rely on here. Dr. Rosenbaum can't find it. Mr. Rosenfield can't find it. I can't find it. The staff can't find it. The chairman of the committee can't find it.

I am sure the legal counsel for the committee, when we get around to holding hearings, won't be able to find it. We don't have any other witnesses who can tell us.

I am just curious who can help me out of this thicket, because I really want to know who this would be.

Mr. HIESTAND. It is page 19, I am sorry, not page 9; I misunderstood him.

The operative definition, as I understand it, on page 18 you have both; 11 is a health care provider and beneath that which—it ties into health care provider—is the health care goods or services.

When you flip over on page 19 of that definition, it says that relates to the diagnosis prevention or treatment of any human disease or impairment or the assessment of the health of human beings. I think that is the limiting language that is supposed to control both the goods and services and who they are provided by.

So I think that was the intent of the drafters here, to make sure it didn't go as broadly.

Mr. DINGELL. To what, though, does that language and that definition refer? I mean, it just sits there in glorious, solitary splendor. I don't think it refers to anything.

Mr. HIESTAND. Well, it might well be tightened up. But it says that relates to—you don't—if you are providing services that relate to diagnosis prevention or treatment of human disease, that eliminates a whole lot of other services.

Mr. DINGELL. I have to assume that you would advocate that if this defect is—as it appears at this time, that it be corrected, wouldn't you?

Mr. HIESTAND. Well, I think one ought to look at it to see if it should be tightened, yeah. I mean, you raise and the professor raises a legitimate point for consideration.

But I am just saying, the bill, I think, does intend to try to relate it, in the language on the top of page, to narrow it, and the language on the top of page 19 reflects that.

Mr. GREENWOOD. The time of the gentleman has expired.

Mr. DINGELL. I would love to see to what it refers, but it doesn't say what it refers to. It just defines. That is different.

Mr. GREENWOOD. If the gentleman from—

Mr. DINGELL. I notice my time has expired, Mr. Chairman.

Mr. GREENWOOD. It has. Perhaps you noticed me telling you that.

Mr. DINGELL. I am sorry, Mr. Hiestand. This has been a fascinating discussion. You haven't helped me, but I know you have tried hard, and I thank you.

Mr. GREENWOOD. Mr. Strickland is recognized for 3 minutes.

Mr. STRICKLAND. Thank you, Mr. Chairman. I am going to continue my line of questioning because, you see, you folks come here and I don't think any of you are under a subpoena to do so. You come here willingly to talk with us about this important issue and, hopefully, to affect our thinking about it. So I think we have got a right to explore your thinking. And I think that means you have got a right to answer or an obligation, a responsibility to answer the question.

So I will go on down.

Mr. Rosenfield, do you feel like Ms. Lewinski should have been limited to a compensation of \$250,000?

Mr. ROSENFIELD. No.

Mr. STRICKLAND. Thank you. I appreciate that concise, direct, understandable answer.

Ms. Rosenbaum.

Ms. ROSENBAUM. I don't, and I think the distinction between the two kinds of recoveries are a terrible example of legalisms.

Mr. STRICKLAND. Could I ask you this then? Do you think perhaps if we are going to consider capping noneconomic damages, that it is fair to consider capping economic damages?

Ms. ROSENBAUM. I think the issue is that an individual who is damaged or injured should recover. I think the attempt to distinguish is shown in all of its futility in a case like Ms. Lewinski's.

Mr. STRICKLAND. And I think it portrays a utilitarian view of human beings, that I find incredibly offensive.

Mr.—I am sorry, I can't see your name tag.

Mr. SMARR. My name is Larry Smarr.

Mr. STRICKLAND. Larry. Respond.

Mr. SMARR. Well, my short answer is, I need more information. And let me tell you why.

Mr. STRICKLAND. Okay. And that is a fair response.

Mr. SMARR. Well, as I understand it—and I don't know if I heard everything here—the total amount received was \$1 million in noneconomic damages, and I would expect under—

Mr. STRICKLAND. It was not, we are being told.

How much it was, Ms. Lewinski?

Ms. LEWINSKI. Well, the jury awarded me \$3 million, but because of the lack of insurance of the doctor, I received a substantial amount less.

Mr. STRICKLAND. Did you receive less than \$1 million?

Ms. LEWINSKI. Yes, sir.

Mr. STRICKLAND. While I am talking with you, who has paid for your surgeries, your multiple surgeries?

Ms. LEWINSKI. Insurance.

Mr. STRICKLAND. Your father's insurance, I understand.

Ms. LEWINSKI. Correct.

Mr. STRICKLAND. Okay. Continue.

Mr. SMARR. Well, I would expect in most cases—and I am not sure about this one—that there would be considerable economic damages that would be awarded. And that is why I need more information to know the actual amount.

But to get to your question about 250 and is that sufficient for noneconomic damages, I think we are really at a societal question here, and that is whether there is enough money in the system to pay the unlimited awards because—

Mr. STRICKLAND. Can I interrupt you? I have got 15 seconds, and I want to get to the good doctor. And I want to tell you, my very best friend is a pediatric surgeon, and I go through these conversations with him all the time.

I don't want this hearing to end without expressing to you that there is no professional group that I have more respect for and that I value more than those who provide medical services to our people. And so I hope anything that I say is not construed as an attack upon the medical profession that I truly admire and honor. Thank you very much.

Thank you, Mr. Chairman.

Mr. GREENWOOD. Mr. Stupak, if he has caught his breath, is recognized for 3 minutes.

Mr. STUPAK. Thank you, Mr. Chairman. I had to run from the floor, but I appreciate that.

Heather, thank you for testifying; your testimony is certainly helpful to all of us as we try to wrestle with this issue.

Mr. Smarr, you had indicated at one time during testimony today that the \$250,000 cap you thought was reasonable and fair. Is that correct?

Mr. SMARR. Yes, sir.

Mr. STUPAK. Okay. In 1975, when California put on their \$250,000 cap, did you think it was fair then?

Mr. SMARR. I wasn't aware of it then, but yes, I believe it was.

Mr. STUPAK. Okay. Well, today that \$250,000 cap in 1975, by today's value—is \$40,389 by today's actual dollars when compared to 1975. Do you think that is fair?

Mr. SMARR. I think that it is very hard to determine a level for noneconomic damages when it is an issue that is just unmeasurable.

Mr. STUPAK. Okay. So yes or no. I am just——

Mr. SMARR. Yes, I think that \$250,000 is the correct level for it today.

Mr. STUPAK. Even today?

Mr. SMARR. Today.

Mr. STUPAK. So the \$250,000 that California put in in 1975, if you took it to today's value, it is \$1,547,461 in 2002 dollars. Is that fair?

Mr. SMARR. Is that calculation fair or is that a fair amount?

Mr. STUPAK. Do you think that is a fair amount for noneconomic damages?

Mr. SMARR. West Virginia has a \$1 million limit, which is similar to the number you are citing, and West Virginia is one of the most troubled States in the Nation with regard to medical liability incidents.

Mr. STUPAK. So you don't think that is fair for noneconomic damages?

Mr. SMARR. I think it is too high.

Mr. STUPAK. We have heard a lot of people throw around the figure, or not the figure, but the phrase "noneconomic damages." some have even claimed that they are frivolous, pain and suffering. But this is much more than pain and suffering, isn't it?

Mr. SMARR. Yes. There are different categories of things that are deprived that——

Mr. STUPAK. Well, let me tell you, the standard jury instructions that we use probably everywhere in the State describes noneconomic damages to compensate for real, permanent harms that are not easily measured in terms of money, as we have seen by just the answers there, to compensate for these injuries; and they include noneconomic damage injuries—blindness, physical disfigurement, loss of fertility, loss of sexual function, loss of a limb, loss of mobility, and loss of a child.

Do you think that \$250,000 is a fair cap for those noneconomic damages? That is the real definition of noneconomic damages; it is more than just pain and suffering.

Mr. SMARR. I believe that \$250,000 is the appropriate cap for this legislation.

Mr. STUPAK. Okay.

Mr. Hurley, you had indicated in response to Mr. Strickland that you thought health care should be for everyone. All of us up here certainly agree with that and access to it.

But do you believe that the high malpractice premiums for doctors cause patients' health insurance premiums to go up?

Mr. HURLEY. I believe that the high price of malpractice premiums does cost health care—does cause health care costs to go up, yes.

Mr. STUPAK. The Consumer Federation of America, do you know that organization?

Mr. HURLEY. I have heard their name.

Mr. STUPAK. So you don't know if they are a credible group or not?

Mr. HURLEY. I do not.

Mr. GREENWOOD. The time of the gentleman has expired.

Mr. STUPAK. Is it time already?

Mr. GREENWOOD. Time flies when you are having fun, Mr. Stupak.

Mr. STUPAK. I would like to have a little more fun, if you would let me.

Mr. GREENWOOD. You can have as much fun as you want, but not today.

Mr. STUPAK. Could I make a motion though on behalf of this side? Mr. Dingell brought up earlier about the need for having more hearings on this before we go to markup. And I know we are sort of on a fast track, but when we—we are talking about insurance and all that, insurance companies' investments and payrolls and reserve practices and costs of payouts for settlement and claims, it would really be helpful if we had that before we went to a markup, not only to structure amendments, but also to get the full picture out here of insurance premiums, insurance policies.

So I would hope that we would at least get another hearing, at least on the insurance aspect, because as a couple of the members said, we need to look at all the stakeholders here, and the insurance companies certainly are a big one.

I, for one, believe we should take away their antitrust exemption—and to get some competition in here. So could we slow this process down, or—there is no real rush here to do this, other than a calendar that someone created.

Can't we have a hearing on just that aspect of it?

Mr. GREENWOOD. Well, No. 1, I am not empowered. I am not even the chairman of this subcommittee, let alone the chairman of the full committee.

Mr. STUPAK. But you have the Chair right now. You can say that.

Mr. GREENWOOD. I don't think that the gentleman truly means to make a motion to that effect.

Mr. STUPAK. Well, consideration. Do you guys second that motion?

Mr. GREENWOOD. It will be taken into consideration. But you have got two guys here, and I have got just me, so we are not going to vote on it.

Mr. STUPAK. Oh, come on. You mean we can't get democracy in malpractice?

Mr. GREENWOOD. With that objection, I would like to enter the following documents into the record.

One is the National Association of Insurance commissioners' letter to Senator Gregg, dated February 7 of 2003; the Federation of State Medical Boards of the United States of America summary of the 2001 board actions, dated April 9, 2002; the study entitled, Who Pays for Tort Liability Claims: An Economic Analysis of U.S. Tort Liability System, written by the Council of Economic Advisers in April 2002; a study entitled Do Doctors Practice Defensive Medicine, written by Daniel Kessler and Mark McClellan; and a study entitled Did Investments Affect Medical Malpractice Premiums by the Insurance Asset Management Group; as well as documents—exhibits I believe presented by the Democrats, one entitled Medical Malpractice: What Did MICRA Do to California Premiums, and another one entitled California Medical Malpractice Premiums, 1975 to 2001.

Without objection, those documents will be entered into the official record.

We thank the witnesses. You have been here for 4½ long hours without so much as a courtesy break. Thank you for your testimony, every one of you. We appreciate it. This hearing is adjourned.

[Whereupon, at 1:55 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

#### PREPARED STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

This statement is submitted to the Health Subcommittee of the House Energy and Commerce Committee on behalf of the 93,400 members of the American Academy of Family Physicians. This hearing, entitled "Assessing the Need to Enact Medical Liability Reform," is timely. The current lack of professional liability insurance does threaten patient access to care in some states. The continued trend of increasing insurance premiums drives up the cost of health care and forces physicians to drop certain services when they cannot afford professional liability insurance.

#### PATIENTS AFFECTED BY THE LACK OF MEDICAL LIABILITY INSURANCE

Medical liability insurers have left the medical insurance market in the past year in alarming numbers. One major reason for this exodus is the unpredictable rise in jury awards that exists in states without adequate tort reforms. According to the Physician Insurers Association of America (PIAA), the last decade has seen a dramatic increase in awards in excess of \$1 million even while the number of suits filed has remained the same. As a result of the steady rise in record-breaking awards, most insurers find it more difficult to predict their risk. The remaining insurers have raised rates or refused new applications for insurance. Family physicians are beginning to experience difficulty in finding insurance companies to provide liability insurance or are receiving renewal notices with anywhere between 60 percent and 200 percent increases for the second year in a row.

Stories of family physicians closing their practices because of liability insurance premiums are turning up across the U.S. Recently, for example, *AAFP Direct* reported that AAFP Past President Neil Brooks, M.D., sent a letter recently to the *Hartford Courant*, saying that he was giving up his practice of thirty-two years because the liability premiums had become too expensive.

In rural Morrow County, Ohio, Brian Bachelder, M.D., President of the Ohio Academy of Family Physicians, decided to stop delivering babies after his liability premium increased by \$21,000 last year. Dr. Bachelder was the *only* Morrow County physician providing prenatal and obstetrical care.

In rural Chipley, Florida, Greg Sloan M.D., found his malpractice premium has risen from \$4,500 to \$13,600 in one year. This was in spite of a 24-year career with-

out a suit being filed against him. Dr. Sloan said it has reached the point that he cannot pay his staff and the liability premiums.

Most state laws, hospital accreditation requirements and managed care contracts mandate that physicians carry medical liability insurance. If family physicians cannot afford insurance coverage, they must choose between shutting down their practice altogether or restricting the range of services they provide. For family physicians in rural settings, this usually means being forced to stop delivering babies or providing prenatal care due to mounting liability premiums.

The tools needed to counteract this alarming trend are derived from state experiences. Last year, the Department of Health and Human Services released a report entitled, "Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System." According to this study, liability premiums have been growing rapidly in states that have failed to place reasonable limits on non-economic damages. While economic losses, such as lost wages, medical expenses and rehabilitation costs are fully compensated, non-economic damages reflect the monies collected for intangible losses. Over the previous two years, states without caps on these non-economic damages have experienced a 44-percent increase in liability premiums. In contrast, states with caps on non-economic damages of \$250,000 experienced on average an increase of only 15 percent in medical liability insurance premiums.

The reforms contained in California's Medical Injury Compensation Reform Act of 1975 (MICRA) have already brought stability and fairness to the California legal system for the past 27 years. Californians Allied for Patient Protections (CAPP), a major consumer group supportive of MICRA, found that legal disputes in California are settled 23 percent faster than the national average. At the same time, the number of suits filed in California matches the national average. In the ensuing 27 years, medical liability insurance premiums have risen 505 percent nationwide compared with California's increases of 167 percent.

#### AAFP SUPPORT FOR H.R. 5, THE HEALTH ACT

But the states cannot, by themselves, resolve this national crisis. The House of Representatives addressed this issue by passing, H.R. 4600, The Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act in the 107th Congress. The HEALTH Act has been reintroduced into the 108th as H.R. 5. The Academy supports H.R. 5, which would bring the same rational reforms contained in MICRA to all states' professional liability systems. The AAFP supports federal legislation to stabilize the medical tort reform systems in the states since spiraling insurance premiums mean increasing numbers of pregnant women in rural areas of the U.S. will not be able to find a physician to deliver their babies.

There is an important additional reason that the AAFP supports The HEALTH Act. H.R. 5 requires that a party pay damages only to the extent that the party was liable for the harm caused. Family physicians provide primary care which is comprehensive and coordinated care for all life stages and both genders. Because they are the overall medical managers for a vast number of patients in the U.S., with responsibility for making referrals to subspecialists, family physicians need the protections of joint and several liability reforms to ensure that they are not held responsible for the clinical decisions of others.

#### CONCLUSION

The Academy appreciates the opportunity to address the Health Subcommittee of the Energy and Commerce Committee regarding the need to pass medical liability reform. We look forward to working with the Committee to find a workable solution for patients and physicians.

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#### PREPARED STATEMENT OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

On behalf of the American College of Obstetricians and Gynecologists (ACOG), an organization representing more than 45,000 physicians dedicated to improving the health care of women, we urge you to bring an end to the excessive litigation restricting women's access to health care.

ACOG resoundingly supports HR 5, the bipartisan HEALTH Act of 2003, and we urge this Committee, and the House of Representatives, to pass this meaningful medical liability reform legislation, which protects women's access to health care.

Across the country, the meteoric rise in medical liability premiums is threatening women's access to health care. Faced with the unaffordability and unavailability of



insurance coverage, ob-gyns are forced to stop delivering babies, reduce the number of deliveries, scale back their practices by eliminating high-risk procedures, or close their doors entirely.

This statement will also highlight how the medical liability crisis is acutely affecting a growing number of states, explaining how access to basic and important women's health care in those states is severely jeopardized because of a liability system gone awry.

#### I. EFFECTS OF EXCESSIVE LITIGATION ON WOMEN'S HEALTH CARE: AN OVERVIEW

The number of lawsuits against all physicians has been rising over the past 30 years in an increasingly litigious climate, and obstetrics-gynecology—considered a “high risk” specialty by insurers—remains at the top of the list of specialties affected by this trend.

An ailing civil justice system is severely jeopardizing patient care for women and their newborns. Across the country, liability insurance for obstetrician-gynecologists has become prohibitively expensive. Premiums have tripled and quadrupled practically overnight. In some areas, ob-gyns can no longer obtain liability insurance at all, as insurance companies fold or abruptly stop insuring doctors.

When ob-gyns cannot find or afford liability insurance, they are forced to stop delivering babies, curtail surgical services, or close their doors. The shortage of care soon affects hospitals, public health clinics, and medical facilities in rural areas and inner cities.

Now, women's health care is in jeopardy for the third time in three decades. This crisis will only end soon with legislative intervention. The recurring liability crisis involves more than the decisions of individual insurance companies. The manner in which our antiquated tort system resolves medical liability claims is at the root of the problem.

A liability system—encompassing both the insurance industry and our courts—should equitably spread the insurance risk of providing affordable health care for our society. It should fairly compensate patients harmed by negligent medical care. It should provide humane, no-fault compensation to patients with devastating medical outcomes unrelated to negligence—as in the case of newborns born with conditions such as cerebral palsy. Our current system fails on all counts. It's punitive, expensive, and inequitable for all, jeopardizing the availability of care.

Jury awards, which now soar to astronomical levels, are at the heart of the problem. The average liability award increased 97% between 1996 and 2000, fueled by states with no upper limits on jury awards. The current liability system is enormously expensive, and patients who need, but can't get, health care, pay the price.

The current liability system encourages attorneys to focus on relatively few claims with exorbitant award potential, ignoring other claims with merit. Even then, much of a jury award goes straight into the lawyers' pockets; often, less than half of every medical liability dollar ever reaches the patient.

Patients and physicians need a real solution to this crisis. In the 1980s, the Institute of Medicine warned that the liability crisis compromised the delivery of obstetric care for women across the nation. It urged Congress to provide both immediate relief and long-term solutions. ACOG has asked the Institute to reexamine this issue and update its report.

The liability crisis continues to compromise the delivery of health care today. A recent Harris survey showed that three-fourths of physicians feel their ability to provide quality care has been hurt by concerns over liability cases. And, patients understand the problem, too. An April 2002, survey by the Health Care Liability Alliance found that 78% of Americans are concerned about the impact of rising liability costs on access to care.

#### II. HOW EXCESSIVE LITIGATION COMPROMISES THE DELIVERY OF OBSTETRIC CARE

Obstetrics-gynecology is among the top three specialties in the cost of professional liability insurance premiums. Nationally, insurance premiums for ob-gyns have increased dramatically: the median premium increased 167% between 1982 and 1998. The median rate rose 7% in 2000, 12.5% in 2001, and 15.3% in 2002 with increases as high as 69%, according to a survey by Medical Liability Monitor, a newsletter covering the liability insurance industry.

A number of insurers are abandoning coverage of doctors altogether. The St. Paul Companies, Inc., which handled 10% of the physician liability market, withdrew from that market last year. One insurance ratings firm reported that five medical liability insurers failed in 2001. One-fourth of the remaining insurers were rated D+ or lower, an indicator of serious financial problems.

According to Physicians Insurance Association of America, ob-gyns were first among 28 specialty groups in the number of claims filed against them in 2000. Ob-gyns were the highest of all specialty groups in the average cost of defending against a claim in 2000, at a cost of \$34,308. In the 1990s, they were first—along with family physicians-general practitioners—in the percentage of claims against them closed with a payout (36%). They were second, after neurologists, in the average claim payment made during that period (\$235,059).

Although the number of claims filed against all physicians climbed in recent decades, the phenomenon does not reflect an increased rate of medical negligence. In fact, ob-gyns win most of the claims filed against them. A 1999 ACOG survey of our membership found that over one-half (53.9%) of claims against ob-gyns were dropped by plaintiff's attorneys, dismissed or settled without a payment. Of cases that did proceed, ob-gyns won more than 65% of the cases resolved by court verdict, arbitration, or mediation, meaning only 10% of all cases filed against ob-gyns were found in favor of the plaintiff. Enormous resources are spent to deal with these claims, only 10% of which are found to have merit. The costs to defend these claims can be staggering and often mean that physicians invest less in new technologies that help patients.

When a jury does grant an award, it can be exorbitant, particularly in states with no upper limit on awards. Jury awards in all civil cases averaged \$3.49 million in 1999, up 79% from 1993 awards, according to Jury Verdict Research of Horsham, Pennsylvania. The median medical liability award jumped 43% in one year, from \$700,000 in 1999, to \$1 million in 2000: it has doubled since 1995.

Ob-gyns are particularly vulnerable to this trend, because of jury awards in birth-related cases involving poor medical outcomes. The average jury award in cases of neurologically impaired infants, which account for 30% of the claims against obstetricians, is nearly \$1 million, but can soar much higher. One recent award in a Philadelphia case reached \$100 million.

We survey our members regularly on the issue of medical professional liability. According to our most recent survey, the typical ob-gyn is 47 years old, has been in practice for over 15 years—and can expect to be sued 2.53 times over his or her career. Over one-fourth (27.8%) of ACOG Fellows have even been sued for care provided during their residency. In 1999, 76.5% of ACOG Fellows reported they had been sued at least once so far in their career. The average claim takes over four years to resolve.

This high rate of suits does not equate to malpractice. Rather, it demonstrates a lawsuit culture where doctors are held responsible for less than perfect outcome. And in obstetrics and gynecology, there is no guarantee of a perfect outcome, no matter how perfect the prenatal care and delivery.

### III. WOMEN'S HEALTH CONSEQUENCES OF EXCESSIVE LITIGATION

The medical liability crisis affects every aspect of our nation's ability to deliver health care services. As partners in women's health care, we urge Congress to end the medical liability insurance crisis. Without legislative intervention at the federal level, women's access to health care will continue to suffer.

This crisis is obstructing mothers' access to obstetric care. When confronted with substantially higher costs for liability coverage, ob-gyns and other women's health care professionals stop delivering babies, reduce the number they do deliver, and further cut back—or eliminate—care for high-risk mothers. With fewer women's health care professionals, access to early prenatal care is reduced, depriving women of the proven benefits of early intervention.

Excessive litigation also threatens women's access to gynecologic care. Ob-gyns have, until recently, routinely met women's general health care needs—including regular screenings for gynecologic cancers, hypertension, high cholesterol, diabetes, osteoporosis, sexually transmitted diseases, and other serious health problems. Staggering premiums continue to burden women's health care professionals and will further diminish the availability of women's care.

Federal legislation is needed to avert another rural health crisis. Women in underserved rural areas have historically been particularly hard hit by the loss of physicians and other women's health care professionals. With the economic viability of delivering babies already marginal due to sparse population and low insurance reimbursement for pregnancy services, increases in liability insurance costs are forcing rural providers to stop delivering babies.

This crisis also means that community clinics must cutback services, jeopardizing the nation's 39 million uninsured patients—the majority of them women and children—who rely on community clinics for health care. Unable to shift higher insur-

ance costs to their patients, these clinics have no alternative but to care for fewer people.

Acting now can save more women from the ranks of the uninsured. Health care costs continue to increase overall, including the cost of private health care coverage. As costs escalate, employers will be discouraged from offering benefits. Many women who would lose their coverage, including a large number of single working mothers, would not be eligible for Medicaid or SCHIP because their incomes are above the eligibility levels. In 2001, 11.7 million women of childbearing age were uninsured. Without reform, even more women ages 19 to 44 will move into the ranks of the uninsured. If fewer doctors are available to deliver babies, the crisis becomes even more acute.

#### IV. WOMEN'S HEALTH SUFFERS NATIONWIDE

As ob-gyns, our primary concern is ensuring women access to affordable, quality health care. It is critical that we maintain the highest standard of care for America's women and mothers. Currently, ACOG has identified a medical liability crisis in the following nine "Red Alert States": Florida, Mississippi, Nevada, New Jersey, New York, Pennsylvania, Texas, Washington, and West Virginia. In three other states—Ohio, Oregon, and Virginia—a crisis is brewing, while four other states—Connecticut, Illinois, Kentucky and Missouri—should be watched for mounting problems.

In identifying these states, the College considered a number of factors in the escalating medical liability insurance crisis for ob-gyns. The relative weight of each factor could vary by state. Factors included: the lack of available professional liability coverage for ob-gyns in the state; the number of carriers currently writing policies in the state, as well as the number leaving the medical liability insurance market;—the cost, and rate of increase, of annual premiums based on reports from industry monitors; a combination of geographical, economic, and other conditions exacerbating an already existing shortage of ob-gyns and other physicians; the state's tort reform history, and whether tort reforms have been passed by the state legislature—or are likely to be in the future—and subsequently upheld by the state high court.

##### A. Florida

- According to First Professionals Insurance Company, Inc., Florida's largest medical liability insurer, one out of every six doctors is sued in the state as compared to one out of every 12 doctors nationwide.
- In Dade and Broward counties in South Florida, where insurers say litigation is the heaviest, annual premiums for ob-gyns soared to \$210,576—the highest rates in the country, according to *Medical Liability Monitor*.
- In a recent ACOG survey, 76.3% of the Florida ob-gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 21.69% of Florida respondents indicated that they have stopped practicing obstetrics due to the unavailability and unaffordability of liability insurance.
- The liability situation is so severe the state allows doctors to "go bare" (not have liability coverage), as long as they can post bond or prove ability to pay a judgment of up to \$250,000.
- Double and triple-digit premium increases have forced some doctors to cut back on staff, while others have left the state or have stopped performing high-risk procedures. Ob-gyns in this state are more likely to no longer practice obstetrics.
- Florida already has some tort-reform laws aimed at protecting doctors. But more recent Florida Supreme Court rulings have weakened such laws, causing the number of lawsuits to climb again. Now, Florida is one of at least a dozen states contemplating another round of legislation.

##### B. Mississippi

- According to the Mississippi State Medical Association, medical liability insurance rates for doctors who deliver babies rose 20% to 400% in 2002, for various carriers. Annual premiums range from \$40,000 to \$110,000.
- The *Delta Democrat Times* reported that from 1999 to 2000, the number of liability lawsuits faced by Mississippi physicians increased 24%, with an additional 23% increase in the first five months of 2001.

- According to the *Delta Democrat Times*, 324 Mississippi physicians have stopped delivering babies in the last decade. Only 10% of family physicians deliver babies.
- In a recent ACOG survey, 66.7% of the Mississippi ob-gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 12.82% of Mississippi respondents have stopped practicing obstetrics.
- In Cleveland, Mississippi, three of the six doctors who deliver babies dropped obstetrics in October 2001 because of the increase in premiums.
- In Greenwood, Mississippi, where approximately 1,000 babies are born every year, the number of obstetricians has dropped from four to two. The two remaining obstetricians are each limited by their insurance carriers to delivering 250 babies per year, leaving approximately 500 pregnant women searching for maternity care, reports the *Mississippi Business Journal*.
- Yazoo City, Mississippi, with 14,550 residents, has no obstetrician.
- A Grenada, Mississippi ob-gyn recently stopped taking obstetric patients, leaving two ob-gyns to deliver approximately 700 babies a year.
- Natchez, Mississippi, which serves a 6-county population of over 100,000, has only three physicians practicing obstetrics.
- Days before HB2 (legislation aimed at reducing liability insurance costs and improving access to health care) took effect, there was a rush of medical liability lawsuits filed in Mississippi. State Insurance Commissioner George Dale said these claims will be in the system for a long time and the market for medical liability insurance is not likely to get better any time soon.
- The state's major insurer of hospitals, Reciprocal of America, is facing financial difficulties and recently asked participants to pay \$30 million to help keep it afloat, according to the state insurance commissioner's office.

### C. Nevada

- In December 2001, The St. Paul Companies, Inc., the nation's second largest medical liability insurer, announced it would no longer renew policies for 42,000 doctors nationwide—including the 60% of Las Vegas doctors who were insured by St. Paul. Replacement policies are costing some Nevada doctors four or five times as much as before: \$200,000 or higher annually, more than most doctors' take-home pay, the *Los Angeles Times* reports.
- In Las Vegas, ob-gyns paid premiums as high as \$141,760, a 49.5% increase from 2001.
- In the ACOG survey, 86.2% of the Nevada ob-gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 27.59% of Nevada respondents stopped practicing obstetrics.
- As of October 2002, according to Clark County OB-GYN Society, only 80 private practice physicians, 14 HMO physicians, and 12 residents are doing deliveries, totaling 106 doctors. With an estimated 23,000 deliveries expected in Nevada in 2003, each physician will have to deliver 216 babies.
- According to a March article in the *Las Vegas Review-Journal*, many Las Vegas Valley doctors say they will be forced to quit their practices, relocate, retire early or limit their services if they cannot find more affordable rates of professional liability insurance by early summer.
- According to the Nevada State Medical Association, between 200 and 250 physicians will face bankruptcy, close their offices, or leave Nevada this year.
- In February 2002, the *Las Vegas Sun* reported that medical liability cases in Clark County had more than doubled in the past six years. In that period, plaintiffs' awards in the county totaled more than \$21 million.
- *USA Today* reports that in the past two years, Nevada juries have awarded more than \$1.5 million each in six different medical liability trials.
- Recruiting doctors to Las Vegas is extremely difficult because of escalating medical liability premiums and litigiousness. Nevada currently ranks 47th in the nation for its ratio of 196 doctors per 100,000 population. The state's medical school produces just 50 physicians a year.
- The Nevada tort reform legislation went into effect in January 2003. In December 2002, the frequency of lawsuits filed against health care providers skyrocketed with 170 suits filed in December 2002 (as compared to 8 suits filed in 2001).

#### D. New Jersey

- In the ACOG survey, 75.6% of the New Jersey ob-gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 19% of New Jersey respondents have stopped practicing obstetrics.
- In February 2002, the *Newark Star-Ledger* reported that three medical liability insurance companies went bankrupt or announced they would stop insuring New Jersey physicians in 2002 for financial reasons. The state's two largest remaining are rejecting doctors they deem high risk.
- MBS Insurance Services of Denville, one of New Jersey's largest medical liability insurance brokers, estimates that approximately 300 to 400 of the state's doctors cannot get insurance at any price.
- According to the Medical Society of New Jersey, premiums have risen 50% to 200% over last year.
- According to the *Star-Ledger*, "An obstetrician with a good history—maybe just one dismissed lawsuit—can expect to pay about \$45,000 for \$1 million in coverage. Rates rise if the physician faces several lawsuits, regardless of whether the physician has been found liable in those cases."
- The president of the New Jersey Hospital Association says that rising medical liability premiums are a "wake-up call" that the state may lose doctors. Hospital premiums have risen 250% over the last three years, and 65% of facilities report that they are losing physicians due to liability insurance costs.

#### E. New York

- New York State faces a shortage of obstetric care in many rural regions. Increasing liability insurance costs will only exacerbate these access problems.
- In the ACOG survey, 67% of the New York ob-gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 19.28% of New York respondents have stopped practicing obstetrics.
- In 2002, an ob-gyn practicing in New York could pay as much as \$115,500 for medical liability insurance, according to *Medical Liability Monitor*.
- In 2000, there was a total of \$633 million in medical liability payouts in New York State, far and away the highest in the country, and 80% more than the state with the second highest total.
- Increased insurance rates have forced some physicians in New York to "quit practicing or to practice medicine defensively, by ordering extra tests or procedures that limit their risk," according to a recent *New York Times* report.
- Physician medical liability insurance costs have historically been a problem in New York State. The legislature and governor had to take significant action in the mid-1970s and again in the mid-1980s to avert a liability insurance crisis that would have jeopardized access to care for patients.

#### F. Pennsylvania

- In the ACOG survey, 77.4% of the Pennsylvania ob-gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 21.61% of Pennsylvania respondents have stopped practicing obstetrics.
- Pennsylvania is the second-highest state in the country for total payouts for medical liability. During the fiscal year 2000, combined judgments and settlements in Pennsylvania amounted to \$352 million—or nearly 10% of the national total.
- From the beginning of 1997 through September 2001, major liability insurance carriers writing in Pennsylvania increased their overall rates 80.7% to 147.8%, according to a January 2002 *York Daily Record* article.
- Philadelphia and the counties surrounding it are hardest hit by the liability crisis. From January 1994 through August 2001, the median jury award in Philadelphia for a medical liability case was \$972,900. For the rest of the state, including Pittsburgh, the median was \$410,000.
- One-quarter of respondents to an informal ACOG poll of Pennsylvania ob-gyns say they have stopped or are planning to stop the practice of obstetrics. 80% of medical students who come to the state for a world-class education choose to practice elsewhere, according to the Pennsylvania State Medical Society.

- On April 24, 2002, Methodist Hospital in South Philadelphia announced that it would stop delivering babies due to the rising costs of medical liability insurance. The labor and delivery ward closed on June 30, leaving that area of the city without a maternity ward. Methodist Hospital has been delivering babies since its founding in 1892.
- Some tort reform measures passed the state legislature (House Bill 1802) in 2002. However, the law did not include: caps on jury awards; sanctions on frivolous suits; changes in joint and several liability; limits on lawyers' fees; or a guarantee that a larger share of jury awards will go to injured plaintiffs.
- The rules for venue of court cases in Pennsylvania are very liberal. Recently approved measures only appoint a committee to study venue shopping, but do not limit the practice.
- Since HB 1802 passed, experts predict a 15% to 20% overall reduction in doctors' liability premiums. But with the 50% to 100% premium increases of the last two years, medical officials believe the bill is not enough to stop physicians from leaving practice or to attract new physicians. Nor do they believe new insurers will begin writing policies in Pennsylvania.

#### G. Texas

- In the ACOG survey, 67.5% of the Texas ob-gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 13.79% of Texas respondents have stopped practicing obstetrics.
- Preliminary results of a recent Texas Medical Association physician survey indicate that:
  - More than half of all Texas physicians responding, including those in the prime of their careers, are considering early retirement because of the state's medical liability insurance crisis.
  - Nearly a third of the responding physicians said they are considering reducing the types of services they provide.
- Medical liability insurance premiums for 2002 were expected to increase from 30% to 200%, according to the Texas Medical Association. In 2001, ob-gyns in Dallas, Houston, and Galveston paid medical liability insurance premiums in the range of \$70,00 to \$160,000.
- The *Abilene Reporter News* reported on October 13, 2002, that the obstetrics unit at Spring Branch Medical Center is set to close December 20, 2002. The hospital's \$600,000 premium for labor and delivery liability was set to increase by 67% next year. In 2001, 1,003 babies were born at Spring Branch Medical Center.
- According to Governor Rick Perry's office, between 1996 and 2000 one in four Texas physicians had a medical liability claim filed against them. In the Lower Rio Grande Valley, the situation is even worse. In 2002, Valley ob-gyns paid liability insurance premiums up to \$97,830, a 34.5% increase from 2001.
- According to a February 2001 Texas Medical Association survey, one in three Valley doctors say their insurance providers have stopped writing liability insurance.
- In 2000, 51.7% of all Texas physicians had claims filed against them, according to the Texas Medical Examiners Board. Patients filed 4,501 claims, up 51% from 1990.
- As many as 86% of medical liability claims filed in Texas are dismissed or dropped without payment to the patient. Yet providers and insurance companies must still spend millions of dollars in defense, even against baseless claims.
- According to a Texas Medical Association study, the amount paid per claim in 2000 was \$189,849 (average for all physicians), a 6% increase in one year.
- Texas has no limits on non-economic damages in medical liability cases, although the legislature enacted such limits in the 1970s as part of a comprehensive set of reforms. The Texas Supreme Court later rejected them in the 1980s.
- Texas has procedures in place to screen lawsuits for merit and to sanction lawyers who file frivolous suits, but these are not enforced uniformly across the state, according to an April 2002 news release issued by Governor Rick Perry.
- Only about 30% of the medical liability insurance market is served by insurance companies that are regulated by the Texas State Department of Insurance and subject to rate review laws, according to Governor Perry's office.

#### H. Washington

- According to *Medical Liability Monitor*, in late 2001, the second largest carrier in Washington State announced that it was withdrawing from providing medical liability insurance for Washington physicians. This decision by Washington Casualty Company impacted approximately 1,500 physicians.
- In 2001, state ob-gyns paid medical liability insurance premiums in the range of \$34,000 to \$59,000. For many physicians, this meant an increase of 55% or higher from the year 2000.
- In the ACOG survey, 57.2% of the Washington ob-gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 15.06% of Washington respondents have stopped practicing obstetrics.
- According to the Pierce County Medical Society, some Tacoma specialists reported 300% increases.
- Unlike California, Washington has no cap on non-economic damages in medical liability cases. The State Supreme Court found a previous cap unconstitutional in 1989.
- In April, *The Olympian* reported that the Washington State Insurance Commissioner's office heard from physicians throughout the state that they might be forced out of Washington because of high medical liability rates or the lack of available insurance.

#### I. West Virginia

- There are only three carriers in the state—including the state-run West Virginia Board of Risk and Insurance Management—currently writing medical liability policies for doctors. Annual premiums range from \$90,700 to \$99,800.
- In the ACOG survey, 82.2% of the West Virginia ob-gyns who responded to the survey indicated that they had made some change to their practice such as retire, relocate, decrease gynecologic surgical procedures, no longer perform major gynecologic surgery, decrease the number of deliveries and amount of high-risk obstetric care. 23.66% of West Virginia respondents stopped practicing obstetrics.
- In 2000, many physicians had problems affording or finding insurance. This urgency prompted Governor Bob Wise to issue a request for proposals to commercial insurance carriers asking them to provide terms under which they would be willing to come to the state. The governor's office received no response at all. To date, some carriers previously active in West Virginia are under an indefinite, self-imposed moratorium for new business in the state, according to the West Virginia State Medical Society.
- Legislation eked out during a grueling special session in the fall of 2001 reestablished a state-run insurer of last resort. However, with rates 10% higher than the highest commercial rate, and an additional 50% higher for physicians considered high risk, the state-run insurer does not solve the affordability problem, according to ob-gyns in the state.
- According to an informal survey of ACOG's West Virginia section, more than half of all ob-gyn residents plan to leave the state once they have completed training because of the state's medical liability insurance climate. A majority of private practitioners who provide obstetric care plan to leave the state if there is no improvement in the insurance crisis.
- West Virginia cannot afford to lose more doctors. The West Virginia State Medical Society reports that a majority of the state is officially designated by the federal government as a health professional shortage area and medically underserved.

#### V. Conclusion

Thank you, Mr. Chairman, for your leadership on this important issue and for the Committee's attention to this crisis. ACOG appreciates the opportunity to present our concerns for the panel's consideration and again urges the passage of HR 5, the HEALTH Act of 2003. The College looks forward to working with you as we push for a solution.

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PREPARED STATEMENT OF AMERICAN COLLEGE OF PHYSICIANS—AMERICAN SOCIETY OF INTERNAL MEDICINE

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM)—representing 115,000 physicians and medical students—is the largest med-

ical specialty society and the second largest medical organization in the United States. We congratulate the House Committee on Energy and Commerce Subcommittee on Health for holding this important hearing on a subject matter that has more relevance today than ever before. Of the College's top priorities for 2003, addressing the health care liability crisis and its impact on access to care is one of the most critical to our members. ACP-ASIM wishes to thank Committee Chairman W.J. Tauzin and Subcommittee Chairman Michael Bilirakis, Committee Ranking Member John Dingell and Subcommittee Ranking Member Sherrod Brown, and other members, for holding this important hearing to discuss the immediate need to enact meaningful medical liability reform.

#### BACKGROUND

Doctors across the country are experiencing sticker shock when they open their medical malpractice insurance renewal notices—if they even get a renewal notice. After more than a decade of generally stable rates for professional liability insurance, physicians have seen costs dramatically increase in 2000-2003. And in some areas of the country, premiums have soared to unaffordable levels. According to the *Medical Liability Monitor*, in mid-2001, insurance companies writing in 36 states and the District of Columbia claim to have raised rates well over 25 percent. Unfortunately, rates continue to rise dramatically with no sign of the market beginning to stabilize.

While obstetricians, surgeons and other high-risk specialists have been hit hard, internists have been one of the hardest hit specialties—having seen a record nearly 50 percent average increase over the last two years. In some cases, physicians, even those without a track record of lawsuits, cannot find an insurance company willing to provide coverage. These physicians are being forced to decide whether to dig deeper and pay the steeper bill, change carriers, move out of state, or retire from the practice of medicine.

Of these options, changing carriers may not even be an alternative. Finding replacement coverage won't be as easy as it was in a buyer's market. Companies writing professional liability coverage are fleeing or being chased from the market. As an example, St. Paul Companies, which insures doctors in 45 states and is the second largest medical underwriter in the country, announced late in 2001 that it no longer would write medical liability policies. It plans to phase out coverage as physicians contracts expire over the next 18 to 24 months. Frontier and Reliance are also gone. Other commercials, such as PHICO, CNA and Zurich, are significantly cutting back. Even some provider-owned insurers, committed to this market by their founders, are pulling back from some states in which they extended sales.

#### THE PERFECT STORM

At a time when the market is squeezing physician and hospital margins, the rise in professional liability insurance may be the deciding factor that contributes to whether physician offices and emergency rooms keep their doors open. Recently, the costs of delivering health care have been driven by increased costs of new technologies; increased costs of drugs that define the standard of care acceptable for modern medicine; the rising costs of compliance under increasing state and federal regulation; the low reimbursement rate under Medicare and Medicaid; and the declining fees from managed care have all been contributing factors that have affected patient access to health care.

Unquestionably, there is real potential that rising insurance rates ultimately will reduce access to care for patients across the country. Indeed, press accounts on a daily basis are demonstrating exactly that from coast to coast. Physician offices and emergency rooms have been closing their doors all across the country due to the exorbitant costs. The states most severely hampered by the spiraling out-of-control rates are: Florida, Georgia, Illinois, Michigan, Mississippi, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, Washington, and West Virginia. Several other states are just beginning to feel the impact.

Some states have tried to address the dramatic increase in professional medical liability insurance rates with very little success. At best, attempts by the states to solve this problem have resulted in only band-aid approaches to the more underlying problem: the escalation of lawsuit awards and the expense of litigation has led to the increase in medical liability premiums. This fact has resulted in many patients not receiving or delaying much needed medical care—a fact Congress can no longer ignore. ACP-ASIM strongly believes that Congress must act to stabilize the market to avoid further damage to the health care system.



## RELIEF FOR PHYSICIANS FROM SOARING MALPRACTICE PREMIUMS

Federal legislation has been introduced in the 108th Congress to help curb the spiraling upward trend in malpractice premiums. **H.R. 5, the “Help Efficient, Accessible, Low Cost, Timely Health Care” (HEALTH) Act of 2003, will attempt to safeguard patient access to care, while continuing to ensure that patients who have been injured through negligence are fairly compensated. ACP-ASIM strongly endorses this legislation as a means to stabilize the medical liability insurance market and bring balance to our medical liability litigation system.** The HEALTH Act achieves this balance through the following common sense reforms:

- Limit on pain and suffering (non-economic) awards. This requirement limits unquantifiable non-economic damages, such as pain and suffering, to no more than \$250,000.
- Unlimited recovery for future medical expenses and loss of future earnings (economic) damages. This provision does not limit the amount a patient can receive for physical injuries resulting from a provider's care, unless otherwise restricted by state law.
- Limitations on punitive damages. This requirement appropriately raises the burden of proof for the award of quasi-criminal penalties to “clear and convincing” evidence to show either malicious intent to injure or deliberate failure to avoid injury. This provision does not cap punitive damages, rather, it allows punitive damages to be the greater of two times the amount of economic damages awarded or \$250,000.
- Periodic payment of future damages. This provision does not reduce the amount a patient will receive. Rather, past and current expenses will continue to be paid at the time of judgment or settlement while future damages can be funded over time. This ensures that the plaintiff will receive all damages in a timely fashion without risking the bankruptcy of the defendant.
- Elimination of double payment of awards. This requirement provides for the jury to be duly informed of any payments (or collateral source) already made to the plaintiff for her injuries.
- A reasonable statute of limitation on claims. This requirement guarantees that health care lawsuits will be filed no later than 3 years after the date of injury, providing health care providers with ample access to the evidence they need to defend themselves. In some circumstances, however, it is important to guarantee patients additional time to file a claim. For example, the legislation extends the statute of limitations for minors injured before age 6.
- A sliding scale for contingency fees. This provision will help discourage baseless and frivolous lawsuits by limiting attorney incentives to pursue meritless claims. Without this provision, attorneys could continue to pocket large percentages of an injured patient's award, leaving patients without the money they need for their medical care. The sliding scale would look something like this:
  - Forty percent (40%) of the first fifty thousand dollars recovered
  - Thirty-three and one-third percent (33 1/3%) of the next fifty thousand dollars recovered
  - Twenty-five percent (25%) of the next five hundred thousand dollars recovered
  - Fifteen percent (15%) of any amount recovered in excess of six hundred thousand dollars
- Proportionate liability among all parties. Instead of making a party responsible for another's negligent behavior, this requirement ensures that a party will only be liable for his or her own share. Under the current system, defendants who are only 1 percent at fault may be held liable for 100 percent of the damages. This provision eliminates the incentive for plaintiff's attorneys to search for “deep pockets” and pursue lawsuits against those minimally liable or not liable at all.

These common sense recommendations have been proven to work. The HEALTH Act is largely based on provisions contained in the California Medical Injury Compensation Reform Act (MICRA). Since its enactment in the mid-1970's, the MICRA reforms have helped reduce the overall costs of medical malpractice and have contributed to an increase in patient access to care. During this recent malpractice insurance crisis, California's rates have changed only slightly, while other states have spiraled to out of control levels. ACP-ASIM strongly supports the elements contained in MICRA. Further, we believe that any legislation proposed must include these basic, proven elements in order to assure the stabilization of malpractice premiums.

## CONCLUSION

ACP-ASIM is pleased that the House Committee on Energy and Commerce Subcommittee on Health agreed to conduct this important hearing to address the serious problem of soaring medical malpractice premiums that physicians are facing across the country. **We strongly urge the House Energy and Commerce Committee to pass common sense reform contained in the HEALTH Act that would allow for greater access to care, while adequately compensating injured patients.** We thank the Committee and appreciate the opportunity to present our views.

## PREPARED STATEMENT OF THE COLLEGE OF AMERICAN PATHOLOGISTS

The College of American Pathologists (CAP) is pleased to submit this statement for the record of the Energy and Commerce Health Subcommittee hearing on the need to enact medical liability reform. The College is a medical specialty society representing more than 16,000 board-certified physicians who practice clinical or anatomic pathology, or both, in community hospitals, independent clinical laboratories, academic medical centers and federal and state health facilities.

Pathologists, like all physicians, face severe hardships resulting from the worsening medical liability insurance crisis. For many, just finding coverage has been an arduous task at best and, for some, nearly impossible. Those who have found willing insurers are paying substantially higher premiums—in some cases, several times the previous year's rates—for coverage plans, regardless of their claims history.

The realities of this crisis are clear: Pathologists and other physicians can no longer offer certain procedures or are leaving their practices altogether because of the exorbitant costs of malpractice premiums. These are desperate decisions brought on by a tort system with no mechanism to restrain runaway "pain and suffering" and punitive awards. Damages rise beyond reason and, in the end, all patients and providers suffer as the nation's health care costs soar and access to quality care declines.

Real-world examples in the laboratory community highlight the problem:

- The chief executive of a small, rural Pennsylvania hospital recently told a Senate Appropriations subcommittee that he nearly was forced to close the facility when an insurer declined to renew a malpractice policy for his pathologist, a 17-year practice veteran with no claims history. Only through a last-minute joint underwriting agreement was the pathologist able to retain insurance coverage, which allowed the hospital to continue offering laboratory, blood banking and surgical pathology services and remain open, the executive said.
- A pathology group that provides services to all Hawaii's outer island hospitals and five facilities on Oahu—about 20 pathologists, in all—is, like many physician practices, shopping for a new insurance carrier. The group's current insurer recently sent a renewal notice quoting a four-fold increase in premiums compared with 2002 rates.
- In general, malpractice insurance premiums for pathologists have doubled in the past year, reports JLT Services Corp., the College's member insurance broker. In some locations, particularly urban areas, the increases have been significantly higher. Pathologists have been particularly hard hit by The St. Paul Companies' December 2001 decision to leave the medical liability insurance marketplace. The St. Paul, which provided about 9 percent of all malpractice insurance nationwide at the time, had been the underwriter of the CAP-endorsed Professional Liability plan.

Pathologists and other physicians are increasingly hard-pressed to continue providing services, given the heavy burden rising insurance premiums have placed on their practices. Insurance rates of \$200,000 or more for some high-risk specialties have forced many physicians to limit services, retire early or move to states where reforms have brought greater stability to premiums. The skyrocketing cost of liability insurance comes at a particularly critical time for physicians, who also face a widening gap between Medicare reimbursements and practice costs.

Severe patient access problems brought on by the liability insurance crisis have been documented in at least a dozen states and it is expected that 30 more soon will join that list. In the crisis states, obstetrician-gynecologists have been forced to stop delivering babies, trauma centers have closed and many physicians are grappling with how they can continue to provide other high-risk procedures.

Congress must act now to bring commonsense reforms to America's medical liability system. The CAP strongly supports the approach contained in subcommittee

member Rep. Jim Greenwood's bill, the "Help Efficient, Accessible, Low-Cost, Timely Healthcare Act (HEALTH Act) of 2003" (H.R. 5). This critically important bill would:

- place a reasonable limit (\$250,000) on non-economic damages and no limit on economic damages;
- create mechanisms to ensure that only justifiable punitive damages are paid, with a guideline to limit punitive damages to two times economic damages or \$250,000, whichever is greater;
- structure settlements to be paid in increments, rather than lump-sum payments, so that expenses are reimbursed as they occur and earnings, as they would have accrued;
- establish a three-year statute of limitations, with special provisions for minors.
- establish criteria to ensure that defendants would pay damages in proportion to their fault;
- ensure that states with damage caps in place would be permitted to retain them; and
- set a sliding scale for attorney contingency fees to discourage frivolous lawsuits.

The HEALTH Act can work because it is modeled on a California law that has worked well for nearly three decades. It was enacted in circumstances much like those the nation faces today. California suffered a meltdown of its health care system in the early 1970s and physicians saw their premiums soar more than 300 percent. Liability carriers left the state and some physicians closed their office doors. The Medical Injury Compensation Reform Act, or MICRA, which came into effect in 1976, provided a \$250,000 limit on non-economic damages, unlimited economic damages, a statute of limitations on claims, sliding-scale limits on contingency fees, advance notice requirements before claims were filed, binding arbitration of disputes and periodic payment of future damages.

The effect of this legislation was dramatic. The average liability premiums decreased 40 percent in the 25-year period ending in 2001 (expressed in constant dollars). In 2001, the Medical Liability Monitor published data that demonstrated that the average premium paid by California physicians practicing internal medicine, general surgery and obstetrics/gynecology ranged from 43 percent to 51 percent of the average premiums of their counterparts in Florida, Illinois, New York, Texas and Michigan. This was supported by a 53 percent lowering in the dollar amounts of settlements in California, compared with the nation as a whole.

Our current liability crisis is not one of increasing litigation, but one of unreasonably high judgment amounts. Patients are not eager to sue their doctors. In fact, in 1991, the New England Journal of Medicine reported that only 1.53 percent of those injured by possible medical actions even file a claim. Severity of awards is the problem, and that is what the HEALTH Act of 2003 is designed to address.

The College supports such reforms to promote the basic goal of ensuring access to a wide range of health care services and promoting patient safety and quality medical care. In particular, the College strongly supports the bill's establishment of limits on non-economic and punitive damages. These provisions, combined with a sliding scale limit on contingency fees, make for a strong, positive step toward reforms that benefit the whole health care system and protect patient access to affordable, quality care.

The College thanks Rep. Greenwood and other Energy and Commerce members for their leadership on the medical liability reform issue. The CAP appreciates the opportunity to present its views to the Health Subcommittee and offers its support and continued assistance as Congress works to meet the challenge posed by the nation's liability insurance crisis.

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PREPARED STATEMENT OF MARY R. GREALY, PRESIDENT, HEALTHCARE LEADERSHIP COUNCIL

Our liability system is broken. If it is not fixed soon, it will break our health care system as well.

One of the founding principles of the Healthcare Leadership Council (HLC) B which represents the CEO's of the nation's leading health care companies and organizations B is that patients should have access to high quality health care. Skyrocketing liability costs threaten patient access to quality care. This is no longer simply about lawyers and doctors. This is about patients.

The cost of excessive jury awards is causing staggering increases in medical liability premiums. Between 1996 and 1999, average jury awards in medical liability cases have increased by 76 percent. These spiraling increases add directly to the

cost of health care, contributing significantly to premium costs and the growing number of uninsured Americans.

Just as harmful to patients and consumers, however, are the indirect costs of the crisis. Patients are increasingly "paying" for excessive litigation by losing access to medical specialists such as obstetricians and surgeons. An estimated 1 in 11 obstetricians/gynecologists say they have strictly limited their services solely to gynecology due to the malpractice crisis. In some areas, the situation is far worse. In Miami, average annual malpractice premiums for Ob-Gyns are \$210,578, while the average salary for an Ob-Gyn in Florida is \$118,435. In Wyoming, premiums average \$116,000, while average salaries for Ob-Gyns are \$108,700.

As medical malpractice insurance rates skyrocket B or become unavailable B medical specialists such as neurosurgeons, orthopaedic surgeons and obstetricians/gynecologists are leaving states such as Pennsylvania, Mississippi, West Virginia, New Jersey, Florida and others. While these states have been in the news lately, the crisis goes far beyond the 13 "crisis" states. It is estimated that as many as 30 other states are in "near crisis" and will soon join the ranks of states where patient access is endangered.

Patients also are losing access to nearby hospitals, trauma centers, and other facilities as a result of the crisis. Patients are subjected to, and pay for, unnecessary tests and procedures as physicians must practice "defensive medicine." In addition, patients ultimately are the ones who suffer when new drug therapies and medical technologies are not developed due to litigation or the fear of it.

The cause of the liability crisis is clear. Medical malpractice insurance rates are set prospectively. These rates are set primarily on the basis of projections of jury awards. This trend line is in one direction: straight up. Solving the cost problem requires dealing with the size and unpredictability of these awards. The bottom line is that medical malpractice premiums cannot keep up with claims. A typical state is Oregon, where a Governor's task force reported that medical liability insurers paid out \$71 million in losses and defense costs, while receiving \$50 million in premiums over the same period. In Ohio, medical malpractice insurers are losing \$1.62 for every \$1 in premiums. Clearly these trends are unsustainable and will drive more physicians out of practice.

The only proven way to bring these costs under control B while actually enhancing patients' ability to recover economic damages for injuries B are reforms which include capping non-economic and punitive damages, establishing reasonable levels for attorneys' fees, and setting fair share rules for joint and several liability.

HLC strongly supports these and other reforms embodied in the Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2003 (H.R. 5).

We stand ready to work with you to address this growing crisis.

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PREPARED STATEMENT OF RODNEY C. LESTER, PRESIDENT, AMERICAN ASSOCIATION  
OF NURSE ANESTHETISTS

Chairman Bilirakis and Congressman Sherrod Brown, I am Rodney C. Lester, CRNA, PhD, President of the American Association of Nurse Anesthetists (AANA). I appreciate the opportunity to submit for the record a statement on issues surrounding medical liability reform, which are the most challenging facing healthcare today.

For those of you who may be unfamiliar with the AANA, we represent approximately 30,000 Certified Registered Nurse Anesthetists (CRNAs) across the United States. In the administration of anesthesia, CRNAs perform virtually the same functions as anesthesiologists and work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers, health maintenance organizations' facilities, and the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons. Today, CRNAs administer approximately 65% of the anesthetics given to patients each year in the United States. CRNAs are the sole anesthesia provider in at least 65% of rural hospitals, which translates into anesthesia services for millions of rural Americans.

CRNAs have been a part of every type of surgical team since the advent of anesthesia in the 1800s. Until the 1920s, nurses almost exclusively administered anesthesia. In addition, nurse anesthetists have been the principal anesthesia provider in combat areas in every war the United States has been engaged in since World War I. CRNAs provide anesthesia services in the medical facilities of the Department of Defense, the Public Health Service, the Indian Health Service, the Department of Veterans Affairs, and countless other public and private entities. Given the current state of affairs with Iraq and Afghanistan, it is not surprising that our deployed forces depend greatly upon the services and skills of CRNAs.

You may be aware of the widely publicized nursing shortage. While we do not have enough rank and file nurses there is an increasingly acute shortage of CRNAs. Quite simply, there are not enough CRNAs to fulfill the demand. Our News Bulletin tends to be chock full of advertisements for vacant positions. Quite simply if the rest of the economy was similar to the employment situation for CRNAs, our nation would be at full employment.

Hardly a day goes by for most anesthesia practices when a CRNA is not called by an employment recruiter attempting to entice them into seeking additional pay at another group or hospital. Practices are offering bonuses, attractive benefits, and higher pay in order to recruit CRNAs.

We graduate approximately 1,000 students per year and it is not enough to fill the demand. Our Foundation has recently funded a manpower shortage study and its results are expected shortly.

#### HOW ARE CRNAS DIFFERENT FROM ANESTHESIOLOGISTS?

The most substantial difference between CRNAs and anesthesiologists is that prior to anesthesia education, anesthesiologists receive medical education while CRNAs receive a nursing education. However, the anesthesia part of the education is very similar for both providers, and both professionals are educated to perform the same clinical anesthesia services. CRNAs and anesthesiologists are both educated to use the same anesthesia processes and techniques in the provision of anesthesia and related services. The practice of anesthesia is a recognized specialty within both the nursing and medical professions. Both CRNAs and anesthesiologists administer anesthesia for all types of surgical procedures, from the simplest to the most complex, either as single providers or in a "care team setting".

#### WHAT IS OUR EXPERIENCE ON MALPRACTICE INSURANCE?

For the past several years, CRNAs have relied largely on two main major malpractice carriers—St. Paul and TIG. On December 12, 2001, AANA Insurance Services—a wholly owned subsidiary of the AANA—was notified by the St. Paul Companies that it would exit this market and would seek to sell their malpractice book and eventually transition out of the medical malpractice market. We were advised that this difficult decision was based upon "its anticipated worst annual loss in its 148-year old history." The St. Paul further stated that the decision is part of an overall plan "that will put St. Paul on sound financial footing so that they can continue serving their thousands of customers in their other businesses." Their news release goes into more detail concerning losses relative to its losses in malpractice, other insurance lines and those associated with the September 11 terrorist attack.

AANA Insurance Services worked to prepare and assist its policyholders in this transition period and kept them informed of developments relative to their continuing insurance coverage.

The AANA and AANA Insurance Services Staff prepared strategies to respond to this situation proactively to assure a smooth transition for our members insured through St. Paul. We contacted our other carrier at the time, TIG Insurance, to seek support from them assessed other potential medical malpractice carriers to assure that our members have more than one choice for professional liability insurance as we have in the past.

While we were aware that St Paul Companies were experiencing difficulties along with the rest of the insurance industry, we—along with many other providers and perhaps the general public—were surprised by the sudden decision to withdraw completely from the medical malpractice market. St Paul stated that they would do everything possible to make the transition smooth. We had an excellent relationship with the St. Paul and this transition continues.

Following this announcement, we worked even closer with TIG Insurance Company to ensure a smooth transition for the policyholders of AANA Insurance Services. A few months ago, TIG Insurance Company announced it would no longer be providing medical malpractice insurance. Coverage for CRNAs through TIG will not be available after June 30, 2003. TIG's announcement comes almost exactly a year after St. Paul's announcement that it was withdrawing from the medical malpractice marketplace.

On Monday, December 16, 2002, Fairfax Financial Holdings Limited announced that it would be restructuring TIG. Fairfax, the parent company of TIG, is a financial services holding company which, through its subsidiaries, is engaged in property, casualty and life insurance, reinsurance, investment management and insurance claims management.

As part of the restructuring, TIG indicated that it will be discontinuing its program business. Program business, a specialty of TIG's that represents a majority of

its business, is defined as insuring large groups of insured with very similar characteristics. According to Fairfax, TIG's program business was not meeting Fairfax's financial expectations. Unfortunately, all of TIG's medical malpractice business, including the coverage it provides to CRNAs, falls into this program business category.

It should be noted that medical malpractice only accounted for 25% of TIG's program business and TIG's CRNA program was only a small part of the medical malpractice business. Fairfax representatives have informed AANA that the decision to restructure TIG was based neither on the performance of its medical malpractice business in general or its CRNA business in particular.

It is no secret that the number of insurance companies willing to offer medical malpractice coverage has shrunk dramatically over the past few years. Although it's of little consolation, there are many classes of healthcare providers who are facing even greater insurance challenges than CRNAs. While TIG's decision is disappointing, it is not surprising considering the current medical malpractice environment.

Unlike when St. Paul exited from the medical malpractice marketplace, TIG's withdrawal won't be as immediate. TIG will continue to offer both new and renewal policies to AANA members through June 30, 2003. After June 30, 2003, TIG will not provide coverage to new applicants.

Currently AANA Insurance Services provides coverage for members through CNA Insurance Company. It is our understanding that CNA has been approved to do business in 43 states and the District of Columbia. CNA is awaiting approval in the states of Alaska, Nebraska, Nevada, New Hampshire, New York, Vermont and Washington. AANA Insurance Services expects CNA to have approval in all these states by June 30, 2003.

Obviously this has become extremely troubling to our members. While we have an excellent relationship with CNA Insurance Company, CRNAs are increasing concerned that with only one major medical malpractice carrier remaining, issues of coverage could become problematic. It should be noted that unless a CRNA had a particular issue with claims or licensure, coverage could easily be found, whether it was with St. Paul or TIG. That remains relatively true today with the CNA Insurance Company. But with more carriers leaving the marketplace, what does that do to providers? More importantly, what does it mean to patients and consumers? How do we attract more carriers to this market? Without major reforms, will carriers have any reason to go into the market?

#### PATIENT SAFETY

Given the strong safety record of CRNAs, we had no reason to believe then, nor do we now, that there was any nexus between the decision of either St. Paul or TIG to exit the medical malpractice market due to bad claims from CRNAs.

America's CRNAs are committed to advancing patient safety so that actual instances of malpractice are reduced. These commitments including active membership in the cross-disciplinary National Quality Forum (NQF) and the National Patient Safety Foundation (NPSF), closed-claims research that transforms tough cases into educational and practice improvements, and the most stringent continuing education and recertification requirements in the field of anesthesia care. *With CRNAs providing two-thirds of all U.S. anesthetics, the Institute of Medicine reported in 1999 that anesthesia is 50 times safer today than 20 years ago.*

#### OUR DILEMMA

Educational programs that prepare nurse anesthetists rely solely on hospitals, surgery centers and even office based surgical practices to provide students with the required clinical experiences to enable them to become competent anesthesia providers. These healthcare facilities rely on surgeons and other high-risk specialties for their patient admissions. As these high-risk specialties leave, operating rooms close and patients have less access to needed care, and students have less access to patients for clinical training.

Looking at Pennsylvania as an example, the hospitals and surgeons who are part of a healthcare system located in Southeast Pennsylvania have seen their primary premiums increase more than 60 %, their CAT fund increase more than 30%, and their excess premiums increase more than 600%, all within the last year.

The Medical Professional Liability Catastrophe Loss Fund (commonly referred to as the CAT Fund) was established to ensure that victims of medical malpractice are compensated and that medical malpractice insurance is available to health care providers. Health care providers (physicians, surgeons, podiatrists, hospitals and nursing homes) are required to carry a set minimum amount of primary coverage. The

health care providers then must pay a surcharge to the CAT Fund in order to fund a layer of insurance above the primary insurance coverage. Failure to comply with this requirement may result in revocation of one's license.

This is reflective of what other healthcare systems in Pennsylvania are experiencing. In addition that system has seen its high-risk specialty physicians relocate out of Pennsylvania or give up the surgical part of their practice. Each time a physician closes his/her office or reduces practice, employees of their practice lose their job. Fewer high-risk specialists mean fewer cases requiring anesthesia are performed. These are exactly the specialties that nurse anesthesia educational programs rely on to provide their students with the required clinical cases.

As surgeons leave the state or reduce surgery because they can not afford the malpractice insurance there are fewer surgical cases, operating rooms are closed, daily operating room schedules are prolonged, overtime costs increase, hospitals' earn less money, layoffs occur and hospitals close. This directly affects patients' access to needed and timely care, and the ability of our educational programs to provide the necessary clinical experiences to educate nurse anesthetists. If this trend continues unabated, nurse anesthesia educational programs (and other healthcare educational programs) will face accreditation issues, declines in student enrollment and delays in graduation as they struggle to find enough clinical experiences for their students. All of this occurring during a time when there is a critical shortage of anesthesia providers nationwide to provide care to an older and sicker population.

The medical malpractice crisis affects all levels of society. Unlimited individual awards for pain and suffering will severely limit the availability and access to care for the majority. The value we place on timely and complete access to care for all our citizens is reflected in our allowance of an individual's unlimited right to take precedence over the needs of all our people. To insure a healthy society, we must insure access to health care even if it means we place limits on a single category of damages to the individual.

If carriers continue to leave the market and if there should be in difficulty obtaining coverage, it could ultimately mean a slow down for hospitals in providing surgeries. In addition, when CRNAs are employed by hospitals or group practices, these entities have to pick up the tab. If increasing rates continue to become an issue, hospitals will increasingly have to make difficult choices. In those rural hospitals where CRNAs are the sole anesthesia provider, hospitals have no choice if they wish to keep their doors open.

That is why the AANA supports medical liability reform. Many can point an accusatory finger as to why carriers exit the market. However, it makes no sense for an insurer to remain in a market if it cannot do so profitably. High costs and runaway juries and large malpractice awards have become unrealistic and disproportionately high. This is not to say that providers, be they nurses or physicians, should not be held responsible for their actions. All providers must take responsibility. And those providers who may be disproportionately responsible for rate hikes because they have had more than one claim must increasingly take responsibility for their actions as do the nursing and medical boards regulating providers. But by the same token, awards have become too high and many insurers have decided that with the unpredictability of determining how to insure a risk that is seems to be increasingly incalculable, they simply exit the market.

In the last Congress, the AANA was pleased to support Rep. Jim Greenwood's (R-PA) legislation, H.R. 4600. The HEALTH Act would permit individuals to recover unlimited economic damages and allow for non-economic damages or "pain and suffering" up to \$250,000. The states would have the flexibility to establish or maintain their own laws on damage awards. Other provisions in the HEALTH Act address the percentage of damage awards and settlements that go to injured patients as well as allocate damage awards fairly and in proportion to a party's degree of fault and works to decrease the time it takes for a case to settle or go to trial. Similar legislation will be considered in the 108th Congress.

Ultimately, it will be incumbent upon insurers, providers, and yes the trial lawyers to work together to find a common solution that works for consumers and patients.

Again, thank you for the opportunity in allowing us to share our views on medical liability reform with the members of this subcommittee.

[The chart follows:]

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